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ABSTRACT

This document reports on the Health Advocacy Training (HAT) Project which was a 3-year demonstration program of evaluation, training, and technical assistance to improve health aspects of day care programs operating in the Southeastern Region of Pennsylvania. Section I presents an introduction to the project. Section II presents a comprehensive summary of progress towards stated aims and describes the (A) project design, (B) development of evaluation tools and procedures to assess the impact of project activities, (C) recruitment of project participants, (D) development of site specific training and technical assistance, (E) identification of community health service and information resources and development of ongoing support to help trained day care personnel carry out health related functions, and (F) dissemination of project findings. Section III describes the instruments used to gather data. Section IV discusses data collected with the use of the instruments developed by the project and includes actual tables. Section V lists presentations and publications of the project. Numerous tables and figures are included. (MS)

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HEALTH ADVOCACY IN CHILD DAY CARE PROGRAMS

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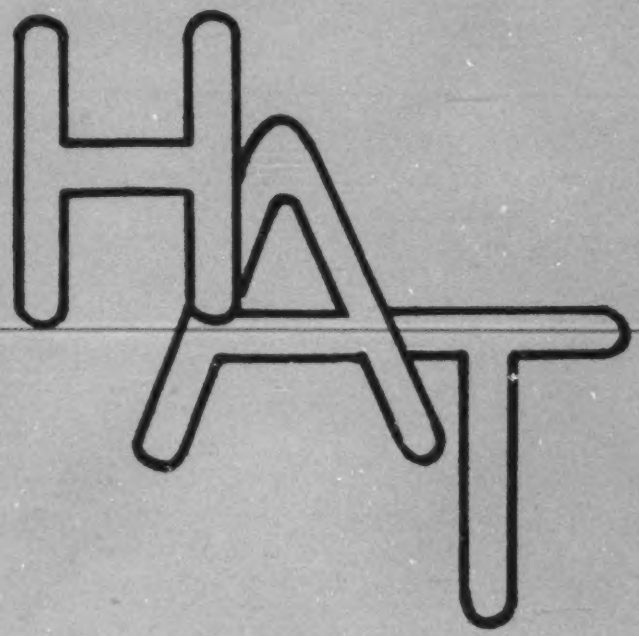
TO IMPROVE THE HEALTH AND SAFETY ASPECTS
OF CHILD DAY CARE PROGRAMS



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HEALTH ADVOCACY IN CHILD DAY CARE PROGRAMS
SUMMARY OF DEMONSTRATION PROJECT REPORT

The Health Advocacy Training Project was a unique three year demonstration of evaluation, training and technical assistance to improve health aspects of day care programs operating in the Southeastern Region of Pennsylvania. The Project was designed to stimulate improvements by evaluating health components at day care sites and by training child day care workers as Health Advocates. Over the course of the demonstration (July, 1973 to September, 1976), 153 child day care sites were involved.

The specific objectives of the Health Advocacy Training Project (HAT) were to:

1. develop a Project design
2. develop an evaluation protocol and instruments to assess the impact of Project activities
3. recruit child day care programs as voluntary participants in the Project
4. develop training and technical assistance for day care personnel including a course curriculum, training materials and follow-up procedures
5. identify community health service and information resources and develop on-going support to help trained day care program personnel carry out health-related functions
6. disseminate the findings and experience of the Project.

Nationally promulgated health and safety standards were used to define the desired accomplishments of child day care health components. HAT Project staff developed the Health Standards Compliance Checklist (HSCC), an instrument to measure program compliance with these standards, as well as other instruments to measure health roles, health knowledge and relevant health opinions of child day care program personnel. The instruments were used in a pre-post test assessment at day care program sites. The pre-tests were administered prior to training of representatives from child day care sites; the post-tests were administered one year after the pre-test. The evaluation design assessed the impact of the evaluation process on health compliance at day care sites as well as the impact of training and technical assistance provided to the participating day care programs.

The Health Advocacy Training Project design required that HAT staff interact with day care personnel from each participating site in multiple activities. Groups of approximately 20 sites entered a sequence of planned Project activities at three month intervals. In all, seven groups of trainees entered and completed the following Project activities:

PRETRAINING: Recruitment of participants, selection of trainees, pre-test evaluation of day care program health components, of prospective trainees and of their supervisors.

TRAINING: A 72 hour (one day a week for a total of 12 days) training course was held at an operational day care center in Philadelphia conducted by a Pediatric Nurse Associate with the assistance of another nurse. Health professionals were involved as guest speakers.

POST-TRAINING: Access to technical assistance, consultative and continuing education services and, one year after the pre-test assessment, a re-evaluation using the same measures used for the pre-test.

RETRAINING: On-site feedback of data collected by the Project with technical assistance provided by Project staff to site staff for continued health component improvement.

Trainees were chosen because they were thought by their programs to be (1) interested in health related matters and (2) potentially able to integrate the role of Health Advocate with other roles they already perform at their sites. Trainees had to have sufficient time to attend the course and to be able to implement their new role on a continuing basis. In the Project, 131 personnel from day care sites serving infants, toddlers, preschoolers, schoolage children, and/or children with disabilities received tuition-free training in health advocacy.

Administrative support for the Health Advocate's role was assumed to be important. Therefore, the trainee's supervisors were involved at several key points: at the pre-training evaluation of the day care site, at a pre-training orientation workshop, in the last session of the training course, at the post-training evaluation of the day care site and at a data feedback meeting with HAT staff arranged by the Health Advocate at the day care site. Day care program health consultants were encouraged to participate with the supervisors in the pre-training orientation workshop, in the last session of the training course and in the data feedback meeting.

HAT provided the following forms of technical assistance to day care programs:

- consultation from trainers to representatives of participating sites and related agencies
- support for a trainee-initiated Health Advocate Alumni Association which met quarterly for continuing education for Health Advocates
- a Newsletter written by trainees and trainers
- development of a library of reference and training materials for use by Health Advocates and HAT trainers
- development of a Registry of Health Consultants

Requests for technical assistance were documented and tabulated as a part of the evaluation design.

During the three year demonstration project, HAT staff developed many materials which were considered helpful and which were requested by individuals and agencies across the nation. Among these materials are:

1. A Training Manual which includes detailed training plans for the 12, six hour training sessions, including the references and handouts used in the course. The Manual can be used in a variety of ways:

   - as a guide to a 72 hour training course

   - as an aid in planning short in-service training sessions on individual topics such as dental hygiene, first aid, management of minor illness, transportation safety

   - as a source of informational handouts and forms which help to organize various types of day care procedures

   - as a source of reference materials to provide greater depth of information than is provided in the training manual itself.

2. Evaluation instruments to measure health component compliance with recommended health standards, health roles, health knowledge and health opinions relevant to the child day care setting.

3. A concept paper prepared for the Department of Health, Education and Welfare on "Health and Safety Issues in Child Day Care" along with a number of other publications describing the HAT Project.

4. Audio-visual aids used to enhance the training of Health Advocates.

In April, 1976, the Health Advocacy Training Project was awarded a contract by the Pennsylvania Department of Public Welfare to provide health, safety and nutrition training to Title XX day care programs in the Southeastern Region of Pennsylvania on a continuing basis. During the transition period from a demonstration to a continuing service project, HAT staff provided training and consultation to Department of Public Welfare day care program monitors so that they could use HAT instruments to conduct annual site evaluations of day care programs.

As a continuing service program, HAT provides the following services on an on-going basis:

1. The 72 hour HAT course for personnel of new sites or sites where the previously trained Health Advocate is no longer at the program.

2. Consultation and training to day care programs based on data collected from the Pennsylvania Department of Public Welfare day care monitors' utilization of a modified version of the Health Standards Compliance Checklist (HSCC-M).

3. Continuing education and consultation for Health Advocates who organize training activities for children, staff and parents at their own sites.

4. Further development and maintenance of the Health Consultant Registry and HAT Lending Library.

5. Consultation to the Pennsylvania Department of Public Welfare on health aspects of local, state and federal policies affecting child day care programs.

The principal findings of the Project are listed below.

1. The Project was able to recruit its target population:

   a. The Trainees:

      - Most were female

      - Seventy percent were between the ages of 21 and 40

      - Slightly more than half were married

      - Two-thirds had children, with the youngest children predominantly being school-age

      - Three-quarters had some education beyond high school

      - Of those who held post-high school level degrees relevant to day care:

        •26% held child development or education degrees

        •25% held social work degrees

        •22% held nursing degrees

      - Most had position titles which were either social work or educational in nature

        •about half held social work positions

        •23% were teachers or caregivers

        •18% were administrators

      - Most received salaries which were less than $10,000 per year

        •about 40% had salaries between $7,001 and $10,000 per year

        •33% had salaries between $5,000 and $7,000 per year

b. The Day Care Sites:

- Both publicly and privately funded sites were represented in every training group, with 83% being federally funded.

- Most (89%) had been in operation over a year.

- All training groups had representatives from sites which served infants, toddlers, preschool, schoolage children and children with disabilities, but most of the sites served preschool children (3 to 6 years).

- Roughly equal numbers of sites represented heterogeneous and homogeneous age groupings.

- The modal (most commonly reported) number of hours of operation per day was 10 hours.

- Median capacity was 40 children with a median enrollment of 39 children.

- Approximately one-third (or 36%) of the sites reported serving only Black children, 30% reported serving both Black and White children; 19% reported serving White, Black and Spanish-American children with the remainder reporting clientele comprising other ethnic combinations.

2. Analysis of course-related trainee behaviors showed:

a. Excluding the Pilot Cycle, the mean enrollment was 19.5 trainees per cycle; Mean attendance per session was 17.1 trainees per cycle. (Each session was taught to half the trainees in a cycle at one time.)

b. Cummulatively, more than 75% of the trainees attending training sessions viewed the training favorably.

c. More than two-thirds of the trainees completed four out of five standard training assignments.

d. Almost all (93%) of the trainees who enrolled, completed the course.

e. Of the trainees who completed the course, 83% were still functioning as Health Advocates at the one year post-test assessment.

3. The pre-test assessment of day care site compliance with health standards showed that levels of compliance across different areas of the health component varied widely:

   a. Compliance was high with standards for planning of the health component by day care program personnel.

   b. Compliance was low for:

      - involving outside health professionals in planning

      - obtaining professional evaluation and plans for management of children known to have or suspected to have special health problems

      - presence of required data on age-appropriate preventive health services in children's medical records.

4. The pre-test data were examined for evidence of sharing of information among sites involved early in the training and sites involved later and for evidence of any overall tendency toward improved compliance with health standards over time unrelated to HAT activities. No such trends were observed. The only exception was that prospective trainees from later cycles tended to mix performance and advocacy of health activities in which they were involved while trainees from earlier cycles tended to report performance only. (Performance is used to mean situations where the Advocate does the activity himself. Advocacy is used to mean situations in which the Advocate involves someone else who does the activity.)

5. As part of the study, supervisors and Advocates were asked to indicate the reasons for each instance of non-involvement in health activities specified by HAT for day care. A common response was that the activity was not planned. The one response which was rarely selected was that the activity was felt by the respondant to be inappropriate in day care. This finding suggests that day care workers agreed that the tasks listed by HAT are appropriate in the day care setting.

6. Comparisons of pre and post training data showed:

   a. Compliance of day care sites with health standards improved after training.

   b. After training, trainees reported greater awareness of the content of the health component and attributed this gain to HAT.

   c. Trainees increased the number of health tasks in which they were involved after training.

   d. After training, trainees performed fewer activities themselves, but more often combined advocacy with performance of tasks.

e. The reported reasons for the Advocate's non-involvement in specific health activities changed. After training, trainees less often reported lack of planning and more often reported that someone else was responsible for the activities in which they were not involved.

f. Trainees and their supervisors reported an increase in the number of instances in which the supervisor rather than the Advocate decides that activities will be carried out. This finding is viewed as demonstrating the Advocate's success in making his supervisor aware of health issues.

g. Trainees demonstrated substantial increase in health knowledge immediately after training. Most of this gain was retained on re-test six to seven months after training was completed.

h. Only a few attitudinal changes were observed. After training, trainee attitudes about the mystique of health professionals changed toward more realistic views. There was also change in attitudes toward seeking out adequate explanations of health concerns from health professionals, toward obtaining personal health data of day care clients if the information can be used to benefit the clients, and toward discouraging unnecessary client dependency.

i. Supervisors of trainees concurred with the trainee's reports of increased involvement with health tasks after training, but did not concur with Advocate's reports that increased time was being spent on health advocacy activities.

j. Supervisors health opinions changed little from pre-test to post-test, but on the pre-test, supervisors already held most of the desired opinions.

7. A site's gain in compliance with health standards was positively associated with:

   a. Percent of health-related activities in which the Advocate is involved

   b. Instances in which the Advocate is not involved but someone else is responsible for particular parts of the health component

   c. Involvement of the Advocate in planning the health component.

8. Multiple regression analyses were performed with gain in compliance in health component areas as criteria and with measures of change in Advocate opinion, knowledge and role as predictors. These analyses revealed that:

   a. The Health Advocate's role is to increase awareness of health issues at the day care site, principally by having input into planning. Thereafter, as input to the health component from a variety of people, including the supervisor, increases, the health component improves.

b. A measured increase in involvement of supervisors suggests that monitoring plus the presence of a trained Health Advocate spurred the supervisor's concern about the health component. Further, after HAT monitoring and training, there was a decrease in failure to comply with standards due to simple lack of planning and an assumption of responsibility for various aspects of the health component by the Advocate and by other people.

c. Gains in compliance in 15 of the 18 health component areas examined were accounted for by positive changes in the Advocate's opinions, knowledge and role in the health component. The analyses of gain in compliance in each area of the health component is summarized and discussed in the report.

9. Day care sites which were subjected to pre and post-tests, but which did not have anyone involved in training, showed some improvement in compliance with health standards. They did not improve as much as sites which participated in training as well as evaluation activities of the Project.

a. Improvements in compliance associated with evaluation alone included the areas of:

- planning and administration of the health component
- handling children's special needs
- content of medical records
- nutrition
- transportation safety

b. Improvements in compliance associated with training, (over that related to evaluation alone) included the areas of:

- health screening
- diagnostic evaluation of health problems and immunizations
- provision or arrangement of treatment services for children
- health policies and procedures of the day care program
- health education
- dental care
- emergency evacuation and disaster planning
- first aid

10. The minimum unit cost of evaluation and training were computed excluding the developmental, administrative and research aspects of the Project.

    a. The cost of one health and safety assessment of a day care site including instrument preparation, data collection and processing was $104 per site.

    b. The unit cost of training including preparation of training materials, review of training plans, site and trainee data and conduct of the training sessions was an additional $104 per site.

11. A number of additional analyses using available data were not performed for this report, but are suggested because of their relevance to current policy issues. The suggested analyses are listed in detail in the report. They include:

    a. An examination of the relationship of a number of variables to gains in compliance: Advocate characteristics, geographic location, clientele served, program funding.

    b. An examination of medical record data to determine which services are least and most commonly recorded in children's day care program health records.

    c. An examination of patterns of utilization of health service providers by day care programs.

    Time and funding needed to perform these additional analyses were not available within the demonstration period.

HEALTH ADVOCACY IN CHILD DAY CARE PROGRAMS

EVALUATION, TRAINING AND TECHNICAL ASSISTANCE
TO IMPROVE THE HEALTH AND SAFETY ASPECTS
OF CHILD DAY CARE PROGRAMS

SECTION I

INTRODUCTION

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SECTION I

INTRODUCTION

This report describes a three year demonstration project developed with the goal of improving the quality of health aspects of public and private child day care programs operating in Southeastern Pennsylvania. To achieve this goal, the Project staff evaluated the health aspects of participating day care sites, trained one person selected by each day care site as a Health Advocate, and provided technical assistance at many levels. No other program of comparable magnitude or evaluative emphasis has been reported to date.

Recent trends have created a need for child day care services. Data collected by the 1974 - 1975 U.S. Population Survey show that of 8 million children ages 3 to 13 usually cared for by someone other than their parents when not in school, 1.8 million care for themselves and nearly 3 million are taken outside their homes to other people's homes or to day care centers for care. One-third of all children under 6 years of age and one-half of those 6 to 17 years of age have a mother who is in the labor force.[1]

As more women join the labor force, the concern of public agencies for the quality of day care provided for children can be expected to increase. Regulations to assure the maintenance of at least minimal standards of quality care are being discussed at many levels of government. Currently, many child care programs are required to comply with multiple regulations of local and state agencies. Some must also comply with federal standards. In recognition of the fact that health and safety concerns are key issues in the maintenance of quality care, most day care regulations include health and safety standards. Because these standards are sometimes technical and difficult to implement within operational constraints, day care program operators tend to view them as more burdensome than helpful. Day care providers need assistance to use these standards as constructive tools for program improvement.

From a child health perspective, child day care can be viewed as an access point to a significant number of families. As providers of family support services, child day care personnel can encourage families to utilize preventive and therapeutic health services appropriately and can promote healthy patterns of daily living. Recently collected data on the status of child health in the United States indicates that the major health problems of America's children are not being adequately managed by our current health system.[2] Although health professionals do not agree about how to make the health system more responsive to unresolved child health problems, they generally agree on the goal: to maximize childrens' potential for leading productive and rewarding lives.

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[1] U.S. Bureau of the Census, Current Population Reports, Series P-20, No. 298, "Daytime Care of Children: October, 1974 and February, 1975", U.S. Government Printing Office, Washington, D.C., 1976.

[2] Neuberger, E., Neuberger, C. and Richmond, J., "Child Health in America: Toward a Rational Public Policy", in The Milbank Memorial Fund Quarterly Health and Society, Vol. 54, Summer, 1976.

Maximizing children's potential is also a goal of providers of child day care services. Given this shared goal as well as their need to comply with imposed health and safety standards, child care personnel can be expected to respond favorably to training which explains the rationale for the standards and which offers feasible methods by which the standards can be met. Work with child day care personnel led the Principal Investigator to believe that many programs accept the need for health and safety standards, but feel they cannot meet them. To address their concerns, training and technical assistance efforts were planned to include not only health and safety principles but also practical suggestions for making changes at their sites.

When the Project was conceived in November of 1972, the health aspects of day care were defined by the following standards:

- The 1969 expanded interpretation of the 1968 Federal Interagency Day Care Requirements (prepared by the U.S. Department of Health, Education and Welfare)
- A draft version of a model day care licensing code (prepared by a national panel of health experts for the U.S. Department of Health, Education and Welfare)
- A prepublication draft of "Recommendations for Day Care Centers for Infants and Children" (published by the American Academy of Pediatrics in 1973)
- Several helpful guidebooks on health, dental health, nutrition and mental health (prepared by the Head Start Program)
- A prepublication draft of "Code for Safety to Life from Fire in Buildings and Structures NFPA 101-1973" (prepared by The National Fire Protection Association)
- Sanitation and safety regulations of municipal, county and state departments of health, education, labor and industry and environmental resources.

These materials, combined with the expertise of the Principal Investigator as a pediatrician, were used to define the recommended standards for the health component of day care promulgated by the Health Advocacy Training Project (HAT). To help day care programs achieve these recommended health standards, the Project's evaluation and training efforts focused on the following areas:

1. Planning and administration of the health component
2. Provision of screening tests
3. Medical evaluation
4. Prevention and treatment services
5. Health education

6. Maintenance and use of health records

7. Environmental quality and safety

8. Nutrition

9. Dental health

10. Mental health

11. Emergency preparedness (including readiness to deliver first aid)

12. Safe and appropriate use of prescribed medications

13. Transportation safety

14. Development and use of health resource information

15. Identification and management of children with illness and disability

16. Staff health

17. Written health policies and procedures (addressing all aspects of the health component in a child day care program)

The Health Advocate's role was defined by the HAT Project to include a set of tasks which would enable a day care program to meet the recommended health standards for child day care. Relevant health opinions were based on a list of attitudes considered by the Principal Investigator to be the attitudes which a successful Health Advocate should hold. Health knowledge was defined as the factual basis required for a Health Advocate to carry out his/her role. It was recognized that the Advocate's success would also depend on support from his/her supervisor and from co-workers. The ability of the supervisor and co-workers to support the Health Advocate's role was thought to depend on their perception of the Advocate's role and their own health opinions. For these reasons, supervisors and co-workers were involved in Project activities.

The Project served a variety of types of child day care programs. Differing regulatory mandates were reflected by sources of funding used by the programs: Head Start, Title IV-A of the Social Security Act and private funding. The type of clientele served differed from site to site since day care service is provided to both homogeneous and heterogeneous populations of infants, toddlers, preschoolers and schoolage children, children with no known disabilities and children with mild to severe problems. Any evaluation, training and technical assistance provided by the Project might be expected to be used selectively according to these pre-existing characteristics, but some change in the direction of improved compliance with health component standards was expected for all participating programs.

The following factors were selected for study because they were expected to related to a day care site's health component compliance:

1. The personal characteristics of the Health Advocate
2. The role of the Health Advocate as perceived by the Advocate and his/her supervisor[3]
3. Relevant health opinions held by the Advocate and his/her supervisor[3]
4. The Advocate's health knowledge
5. The funding and clientele characteristics of the day care program itself

The hypothesized relationship of these factors to health component compliance is shown in Figure 1.

FACTORS RELATED TO HEALTH COMPONENT COMPLIANCE

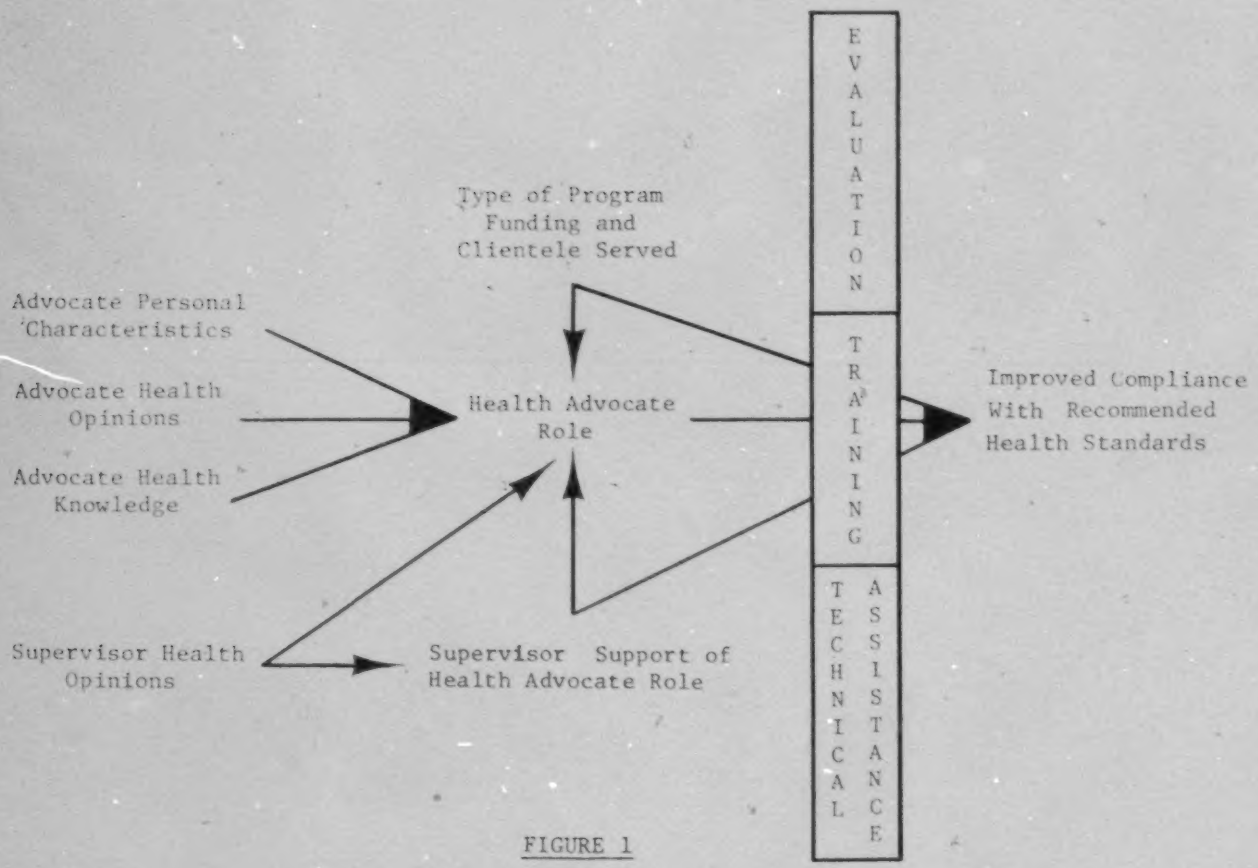


FIGURE 1

[3]The perceptions and opinions of the Advocate's co-workers were also expected to affect the Advocate, but it was only feasible to study the supervisor.

The aims of the Health Advocacy Training Project were to:

A. Develop a Project design

B. Develop an evaluation protocol and instruments to assess the impact of Project activities

C. Recruit child day care programs as voluntary participants in the Project

D. Develop training and technical assistance for day care personnel, including a course curriculum, training materials and follow-up procedures

E. Identify community health service and information resources and develop on-going support to help trained day care program personnel carry out health related functions

F. Disseminate the findings and experience of the Project

The following sections of this report are organized to summarize progress made toward the achievement of the Project's stated aims (Section II), to present the data collection instruments (Section III), to present and analyze data collected with the instruments developed by the Project (Section IV), and to list the publications and presentations which have resulted from the Project (Section V). To aid the reader, tabulated data are presented at the end of each section where the data are discussed.

SECTION II – COMPREHENSIVE SUMMARY OF PROGRESS TOWARDS STATED AIMS

SECTION II – COMPREHENSIVE SUMMARY OF PROGRESS TOWARDS STATED AIMS

A. THE PROJECT DESIGN

The basic design of the Health Advocacy Training Project included the performance of a series of activities in which HAT staff interacted with day care personnel from each participating site. The number of day care sites involved in any one of these activities was limited to the number of sites which could be served simultaneously by the HAT staff. Over 150 day care sites were the target of the Project's activities. To accommodate this number, the sites were grouped to form seven heterogeneous groups with roughly comparable numbers of sites representing different types of regulatory mandates (determined by type of funding) and type of clientele served. The design called for a new group of approximately 20 sites to enter the sequence of planned Project activities at three month intervals beginning in July, 1973. All seven groups had entered the sequence by September, 1975. The last year of the demonstration (September, 1975 to September, 1976) was spent completing the planned sequence of activities for all participating sites, analyzing the evaluative aspects of the Project and arranging for the Project to continue as an on-going source of service.

Each group of day care sites entering the activity sequency together was called a Cycle. The sequence of activities for each participating day care site in a Cycle was as follows:

PRETRAINING:

1. HAT Project staff recruited the day care program to participate in the Project.

2. The participating day care site selected one individual to be trained as a Health Advocate.

3. HAT Project staff evaluated the health aspects of the participating day care programs using instruments designed by the Principal Investigator and the Project's Research Consultant (a research psychologist). This evaluation included assessments of:

   a. The descriptive characteristics of the trainee and of the trainee's program

   b. The site's compliance with recommended standards

   c. Perceptions of the trainee and the trainee's supervisor of the trainee's health-related role

   d. Relevant health opinions held by the trainees and the trainee's supervisor

   e. The trainee's health knowledge.

TRAINING:

4. The Health Advocate trainee attended training, one day a week for 12, six hour sessions designed to change the trainee's health knowledge, health opinions and health role. The 12 training sessions took place on consecutive weeks, except for legal holidays, with a one week break between Sessions 5 and 6 and with a two month interval between Sessions 11 and 12. The training site was an operating day care center in Philadelphia.

POST TRAINING:

5. During the last training session (Session 12), HAT staff re-assessed the trainee's health opinions and health knowledge.

6. HAT staff provided technical assistance and consultative services on request to support the trained Health Advocate's efforts to improve the health component at his/her day care site.

7. One year after the pre-training assessment, HAT staff performed a post-assessment. The same instruments were used in both.

8. All data were tabulated and/or computer scored.

RETRAINING:

9. As computer scores for each site's health compliance data became available, HAT staff contacted the Health Advocate at his/her site to offer to share the data collected from the site with those who could use the data to plan still needed changes. The meeting involved the Health Advocate, the Health Advocate's supervisor, other day care site staff, the local health consultant used by the program and any central administrative staff (if the site was part of a larger agency). This meeting was called the On-Site Retraining Visit (OSRV).

The relation of these steps to each other, including the usual time intervals between steps is shown in Figure 2. The dotted line in Figure 2 represents the possibility that the retraining visit might reveal that staff or site changes have occurred which make it desirable for another staff member to be trained as a Health Advocate.

In addition to performing the described sequence of activities on each site the Project design included a plan for assessing the impact of evaluation procedures alone and documentation of spin-off impacts of the Project's activities at the local, regional, state and national level.

STEPS INVOLVED FOR THE DAY CARE SITES WHO PARTICIPATED IN THE PROJECT

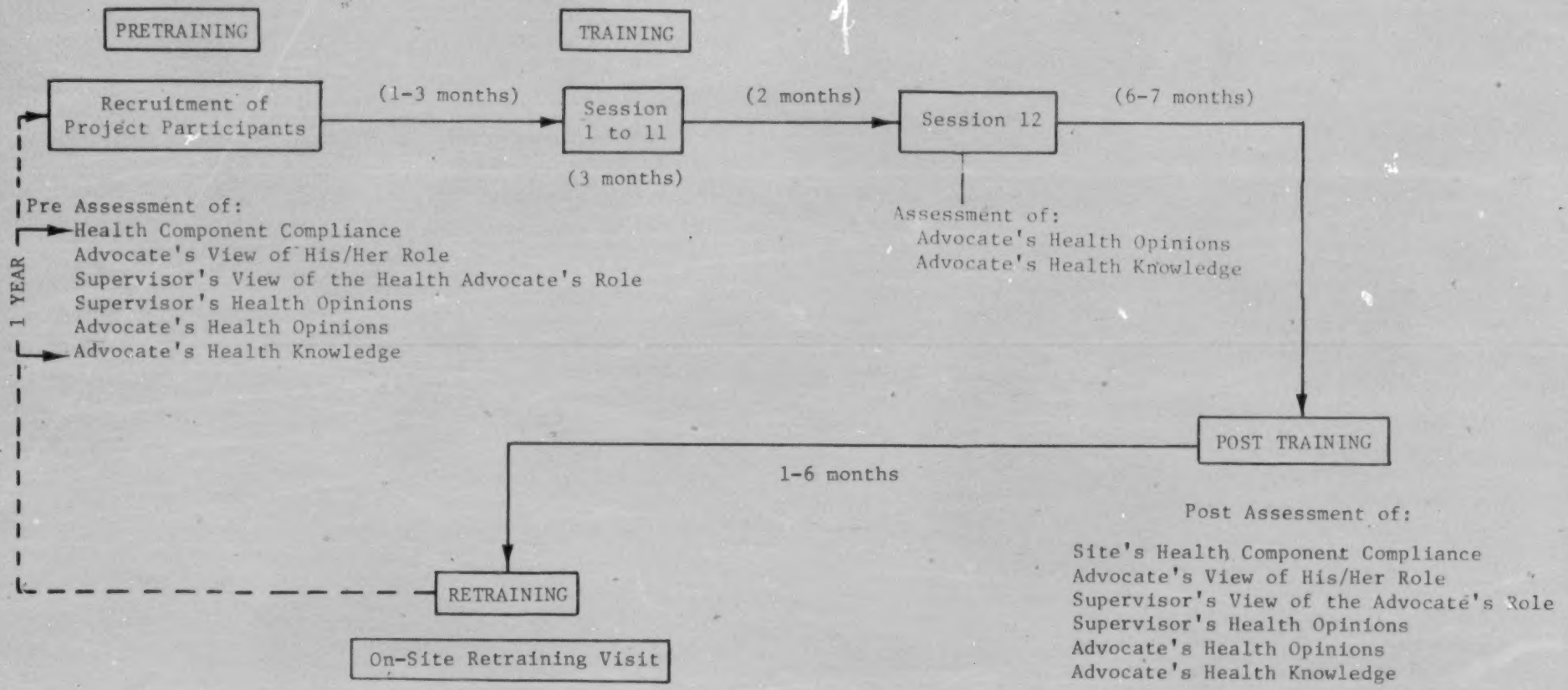


FIGURE 2

B. DEVELOPMENT OF EVALUATION TOOLS AND PROCEDURES TO ASSESS THE IMPACT OF PROJECT ACTIVITIES

1. Overview

The Principal Investigator and the Research Consultant developed evaluation instruments from the day care health component standards, Health Advocate role, relevant health opinions and health knowledge as defined in the introduction of this report. Day care program evaluations were performed by a bachelor's level project staff member called a Field Health Evaluator. The Field Health Evaluator was not exposed to the Advocate's training activities at any time during the data collection process. The Evaluators were trained by the Principal Investigator and demonstrated their consistency and reliability in data collection by performing trial data collection before collecting data used by the Project. A manual which explained each instrument's content and the data collection procedures to be followed was prepared for use by the Evaluators. Over the course of the three year demonstration, five individuals filled two Field Health Evaluator positions.

The evaluation procedures included the administration of the instruments described in the preceding section. In addition to the data collected by the instruments, information was recorded on the number of trainees who completed the course, trainee attendance, tardiness, assignment completion and the trainee's evaluations of the training sessions. Requests for technical assistance and consultation made to the Project were documented throughout the demonstration period using a standard form. Spin-off impacts of the Project and a formative record of Project development were documented in a file called the HAT Process Log. All staff were instructed to send memos describing significant events to be filed in the HAT Process Log.

The pre-training evaluation usually required two separate site visits. The instrument which measured the site's compliance with health standards was administered simultaneously to the Health Advocate, his/her supervisor and any other staff member the site wished to have involved. The administration of the instrument, called the Health Standards Compliance Checklist (HSCC), usually took 2 1/2 to 3 hours. The role, opinion and health knowledge assessments were administered individually to one day care staff member at a time. While the health knowledge and health opinion instruments were self-administered, the Field Health Evaluator was present during the whole process and was responsible for complete collection of all data elements.

After an initial pilot period, instruments and training activities were not modified so that valid pre-post comparisons could be made. The impact of activities operating outside of the Project on participating sites was assessed by examining the pre-training levels of compliance measured at the different points in time when groups of sites entered the Project's sequence of activities. Differences in pre levels were expected to measure the impact of factors unrelated to direct Project interventions.

Although the commitment to keep the instrument and training activities consistent throughout the demonstration period was a necessary scientific constraint, repeated trials revealed aspects of both where changes might enhance their effectiveness. These problems were documented in the HAT Process Log so that

modifications in the instruments and training activities could be made at the end of the demonstration period.

2. Instruments

Brief descriptions of the five major instruments (a.-e. below) are given in Section III of this report. The last two forms are described later in this section (Section II).

a. Trainee Application Form (identifies the characteristics of the trainees and their sites).

b. Health Standards Compliance Checklist (abbreviated HSCC, measures health component compliance with recommended health standards).

c. Role Forms (supervisor and Advocate responses to questions about the Advocate's role).

d. Health Knowledge Test (measures session-by-session factual knowledge as covered in the training course).

e. Health Opinion Survey Forms (supervisor and Advocate responses).

f. Service Request Disposition Form (documents requests for technical assistance or consultation).

g. HAT Group Activity Rating Form (measures session-by-session trainee satisfaction with the training course).

After the demonstration project's data collection was complete, the HSCC was modified for use as a tool for monitoring Title XX day care programs. The staff of the Southeastern Regional Office of the Pennsylvania Department of Public Welfare have helped to develop and test the modified instrument (HSCC-M). The development of a revised instrument and accompanying materials was used as the basis of training provided to Title XX program monitors by the Project. The HSCC-M is being refined for use as part of an annual evaluation of day care programs in the Southeastern Region of Pennsylvania.

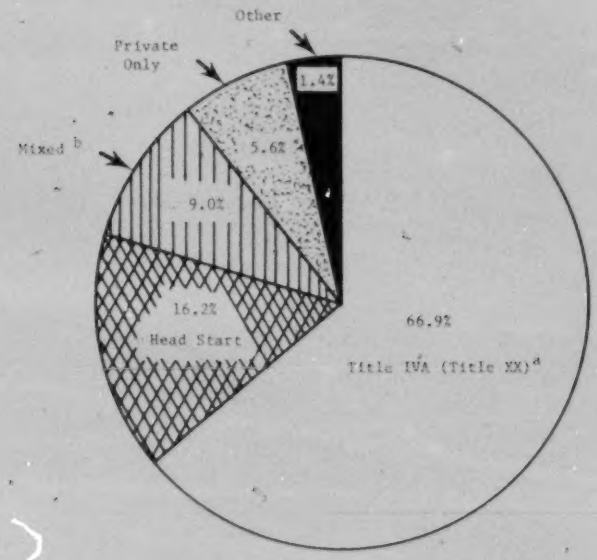
3. Subjects

Six of the seven cycles (Cycles A, B, C, D and G) received comparable treatment by the Project. A Pilot Cycle was conducted during the period July to September, 1973 at which time the training curriculum was tried and modified for later use. A contrast group, Cycle E/F, consisted of programs which were evaluated in the same manner as Cycles A, B, C, D and G but were not offered training until they were re-evaluated one year after their first evaluation.

This design was used to test the impact of evaluation alone on the variables being studied. E sites were located geographically near other sites which had received HAT training; F sites were considered to be geographically and administratively isolated from other participating sites. Cycle E/F trainees were the last to enter training in the demonstration project. At the time of E/F training, replacement sites were added to the E/F Cycle to fill training slots of sites which were unable to enter training. To distinguish the Cycle E/F replacement sites from the original contrast sites, replacement sites were called E/F Nouveau sites. E/F Nouveau site data were treated like that collected from Cycles A, B, C, D and G.

One hundred fifty-three (153) day care sites from Southeastern Pennsylvania participated in the Project during the demonstration period. Participating sites included publicly, privately and mixed funded programs. Among the sites were one group home, one independent family day care home and three multi-site family day care home programs. Some of the programs served infants and toddlers, others preschool children, schoolage children and/or children with special needs (children with disabilities). Composition of the cycles is shown by funding source in Figure 3 and by type of clientele served in Figure 4.

COMPOSITION OF PARTICIPATING DAY CARE SITES IN FUNDING SOURCE
(Cycle A, B, C, D, G, E/F= 142 Sites)

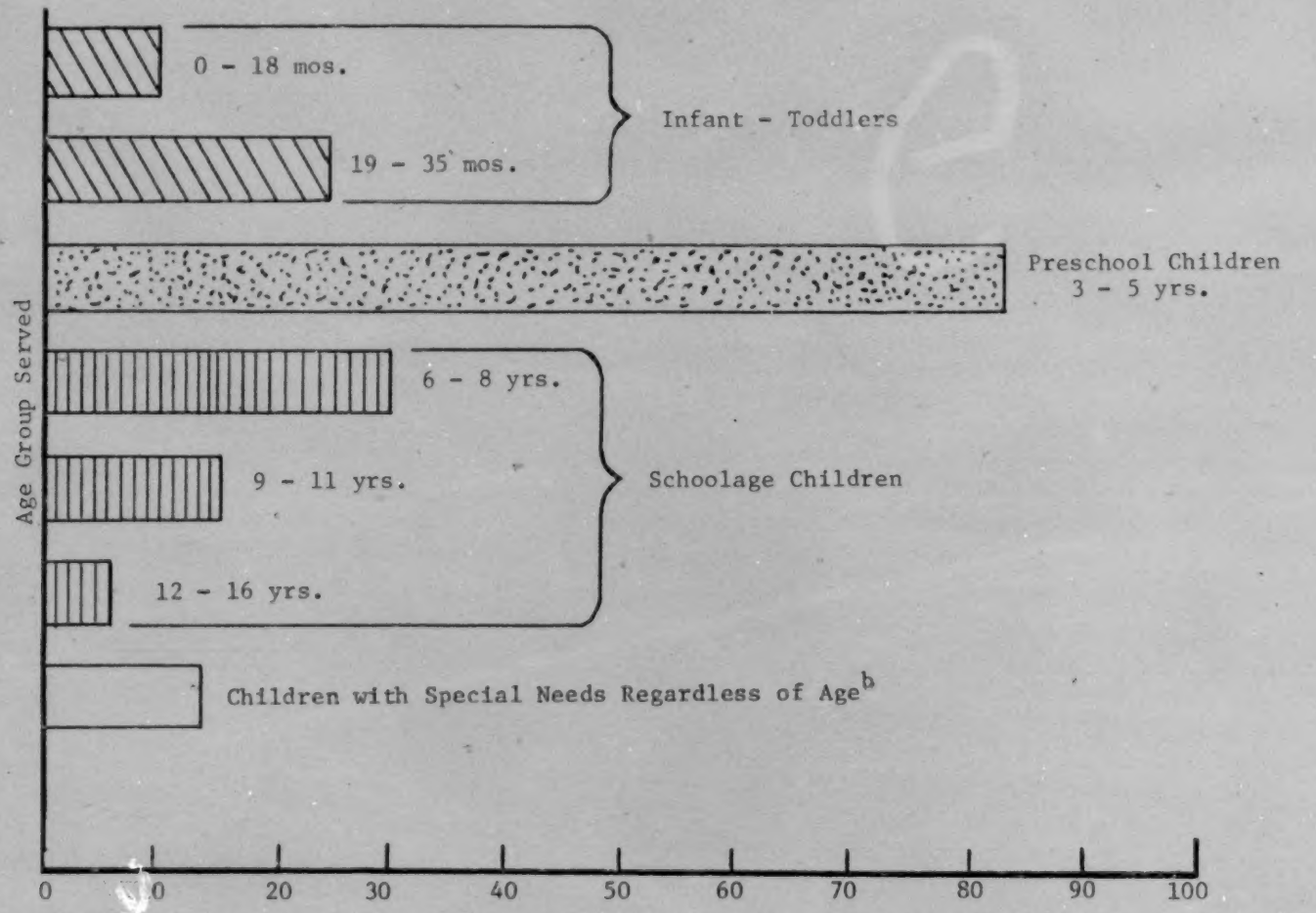


Notes:

[a] During the first part of the demonstration period (1973 to 1976) Title IV-A of the Social Security Act provided funding on a 75/25% matching basis to states which used the funds to purchase or provide day care services for children of working or school-going, low income families under a variety of continually changing eligibility restrictions. In 1975, Title XX of the Social Security Act was passed replacing Title IV-A. Title XX provided funding on a 75/25% matching basis. Day care programs funded under Title XX were required to meet the 1968 Federal Interagency Day Care Requirements.

[b] Includes 1 site which used some Head Start funds, some Title IV-A funds and private fees; 3 sites which used Title IV-A and Head Start funds and 3 sites which used private fees with Title IV-A.

Figure 3



Notes:

[a]Many sites served children of more than one age group.

[b]90% of these sites reported that they only served children with special needs.

FIGURE 4

From the 153 day care sites which participated in the Project, 131 trainees were enrolled in training. The difference in number of trainees and number of sites is accounted for by the trainees who represented multiple sites and the sites which participated in the evaluation but did not send a person to be trained. As shown in Figure 5, of the 131 trainees enrolled, 122 completed the training course, a net loss of 9 trainees (or 7%) between initial enrollment and course completion. Of the 122 trainees who completed the training course, 101 (or 83%) were still acting as Health Advocates at the time of the one year post-evaluation. (For detailed cycle-by-cycle tabulation of data see the end of this Section.)

TRAINEE COURSE COMPLETION AND PERSISTENCE IN HEALTH ADVOCATE ROLE

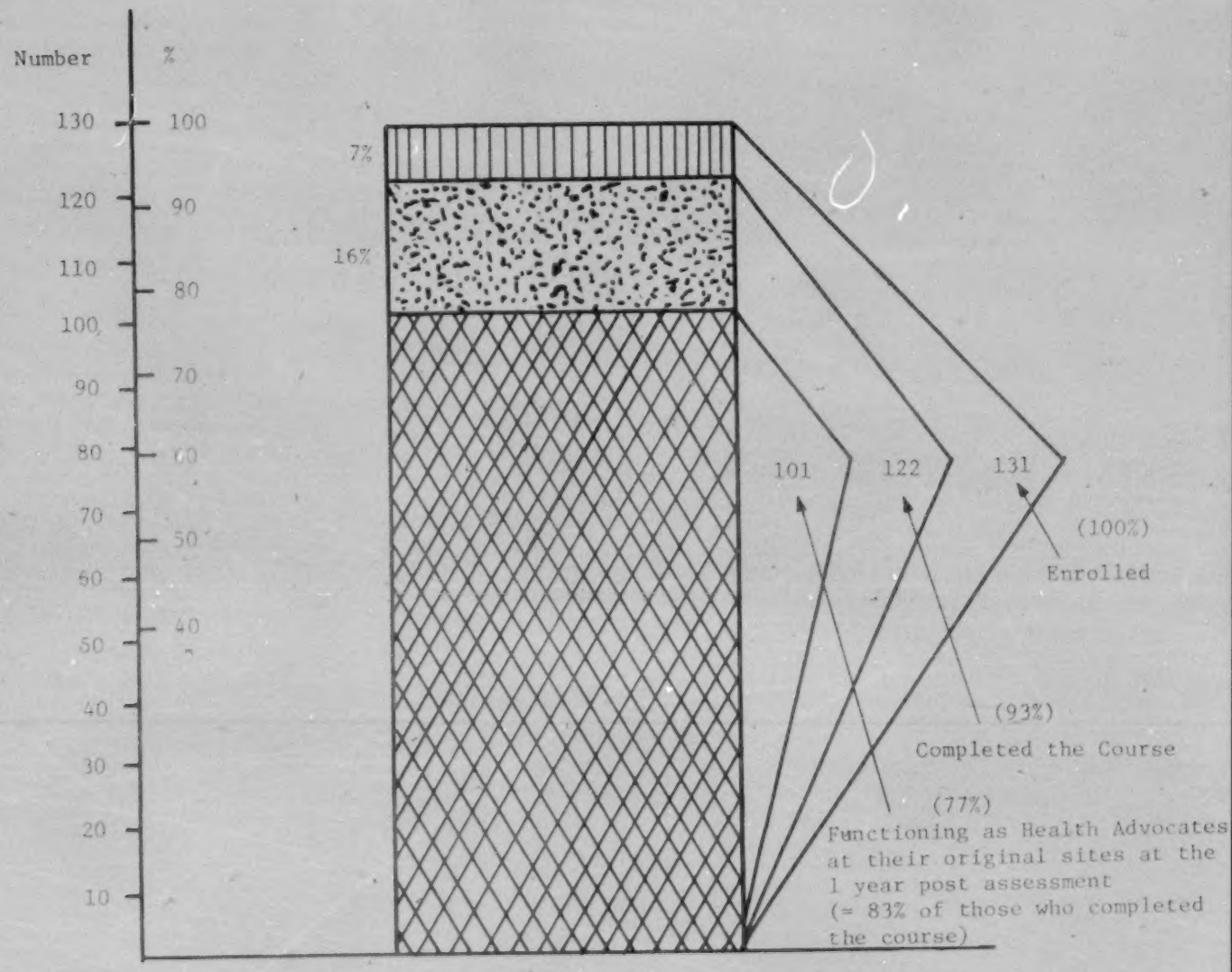


FIGURE 5

C. RECRUITMENT OF PROJECT PARTICIPANTS

As a part of the development of the initial funding application, the Principal Investigator met with key day care program administrators, educational, social service and health staff to solicit their input into the design of the Project. During the first two years of the demonstration period, pre-training involvement of day care supervisors was vigorously solicited. Between February, 1973 and February, 1975 a half-day Supervisors' Workshop was offered a total of 17 times to explain to different day care supervisory and administrative personnel the objectives of the Project, the Project design and the specific commitments required for participation in the Project. The half-day workshops were used to recruit day care sites into the Project and to orient support staff of sites which had already submitted an application for training on the basis of other outreach efforts.

The Workshops helped to gain supervisor support of trainee role changes and to acquaint staff who related in any way to participating day care programs with the objectives and activities of the Project. Health providers were also invited to the Workshop orientation sessions to help them understand that the Health Advocate was not being trained to function as a health professional or paraprofessional in the usual sense, but to enhance the health providers' ability to deliver health services to families and to assist with follow-through on the health professionals' recommendations for patient care. After attending the Workshop, most supervisors and health providers were supportive and agreed to cooperate in the implementation of the Health Advocate's role.

The individual most involved in the Project from each participating day care site was the staff member chosen by the day care program as the most appropriate individual to integrate health advocacy functions with other responsibilities. Although the Project did not exclude parents or volunteers from selection for training, all Advocates chosen by the day care programs were staff members.

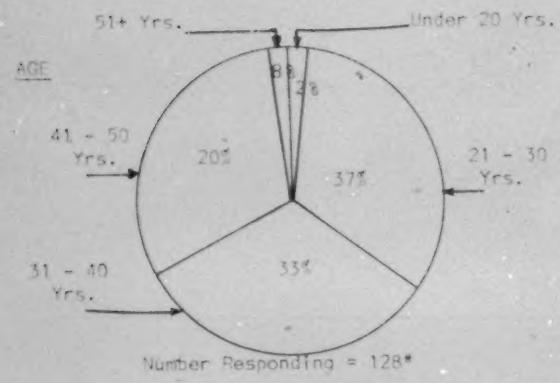
Criteria recommended to the programs for selection of a Health Advocate were: interest in health-related matters, potential for integration of the Health Advocate role with other roles already performed, availability for attending a 12 day training course and time for performing the Health Advocate role on a continuing basis. Recruiting people who already had existing roles in their programs meant that the trainees were already armed with the real-life situations and knowledge of the competing priorities of their programs. They already had a working relationship with other staff and had been recognized by their program as able to undertake role change.

As shown in Figures 6, 7 and 8, most Health Advocates were between the ages of 21 and 40, married females with schoolage children of their own, had at least some college education in the areas of education, social work or nursing and were employed as social service or education staff at their sites. Only 8% held medical titles at their sites and only 18% reported holding some sort of nursing certification. Most of the trainees reported their salaries as between $5,000 and $10,000 per year. Only three trainees represented family day care home sites (although each of these three trainees individually represented multiple sites), the rest were from day care centers.

PRE-TRAINING TRAINEE CHARACTERISTICS

(Pilot, Cycle A, B, C, D, G, E/F= 131 Trainees)

Figure 6



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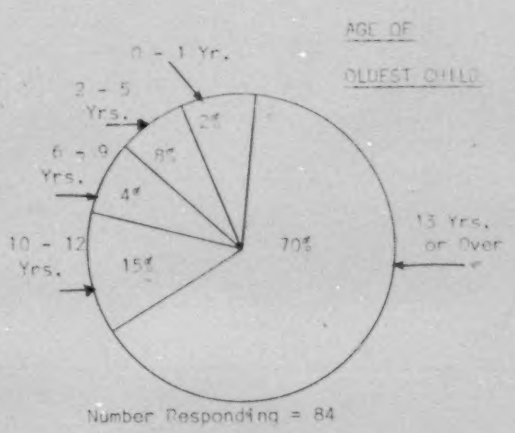

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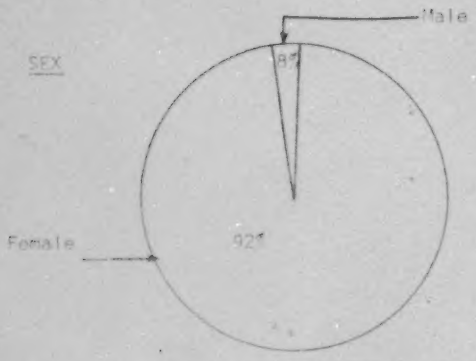

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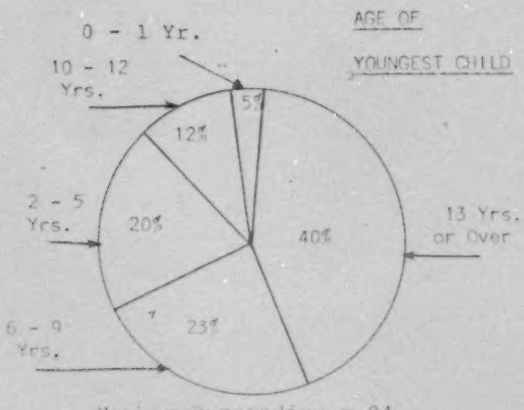

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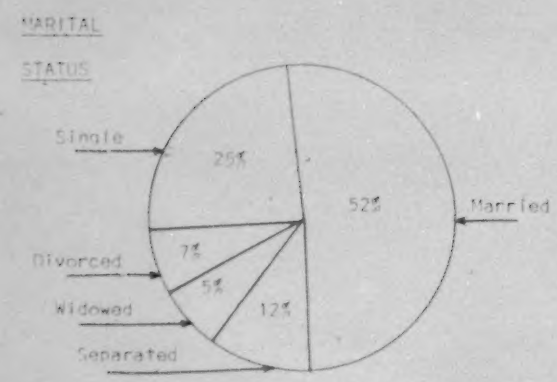

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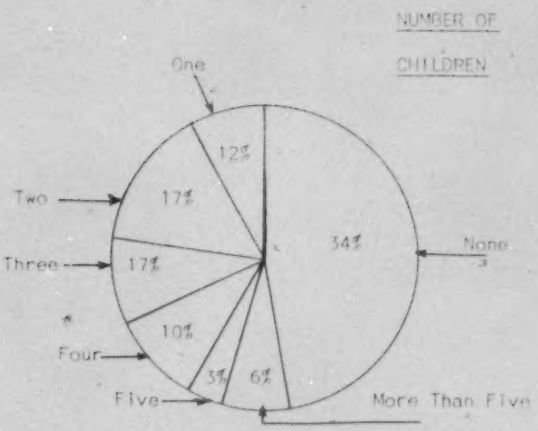
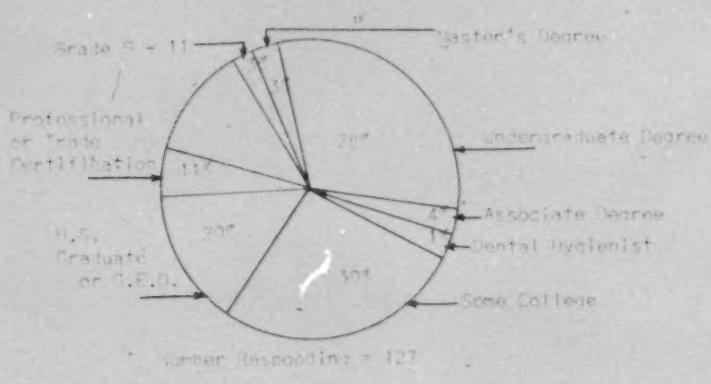


Number Responding = 127

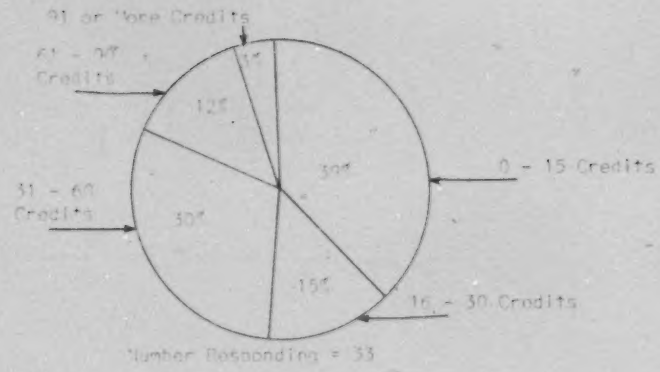
* 3 Pre-training applications were missing at the time of data tabulation.

PRE-TRAINING TRAINEE EDUCATIONAL BACKGROUND

Figure 7

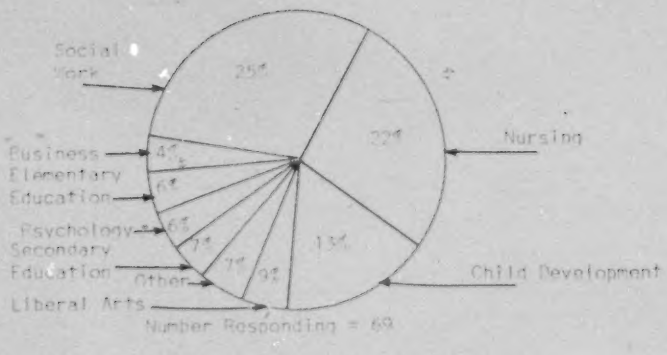


HIGHEST ACADEMIC CERTIFICATION

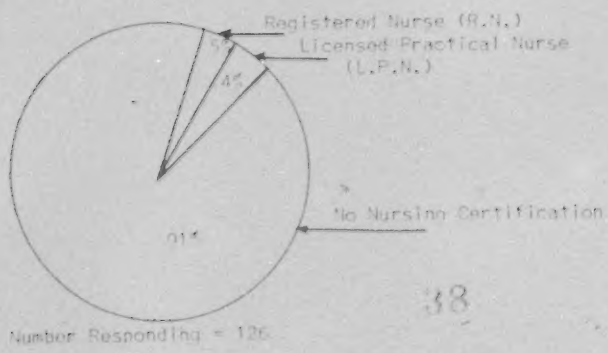


NUMBER OF COLLEGE CREDITS

(For Those Reaching But Not Finishing College)



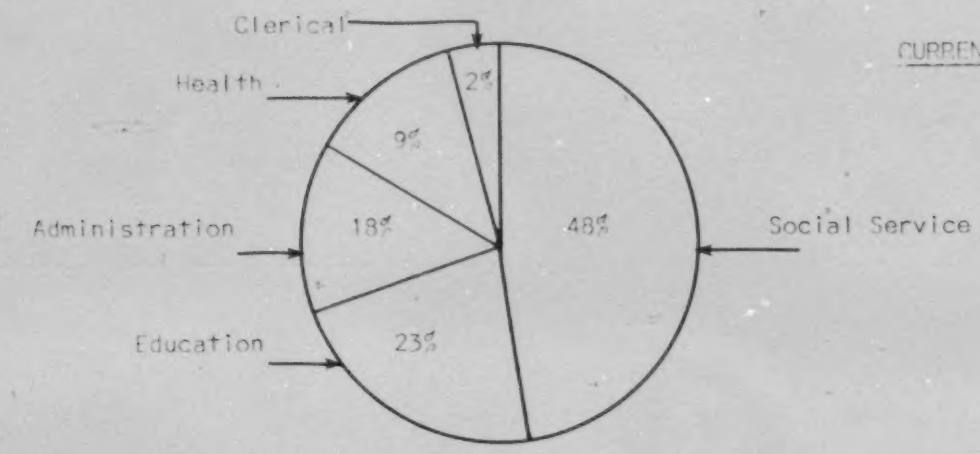
NATURE OF HIGHEST DEGREES, CERTIFICATES OR LICENSES HELD (Of Those Holding Such Credentials)



TYPE OF NURSING CERTIFICATION

FIGURE 3

JOB RELATED CHARACTERISTICS OF TRAINEES



CURRENT JOB TITLE

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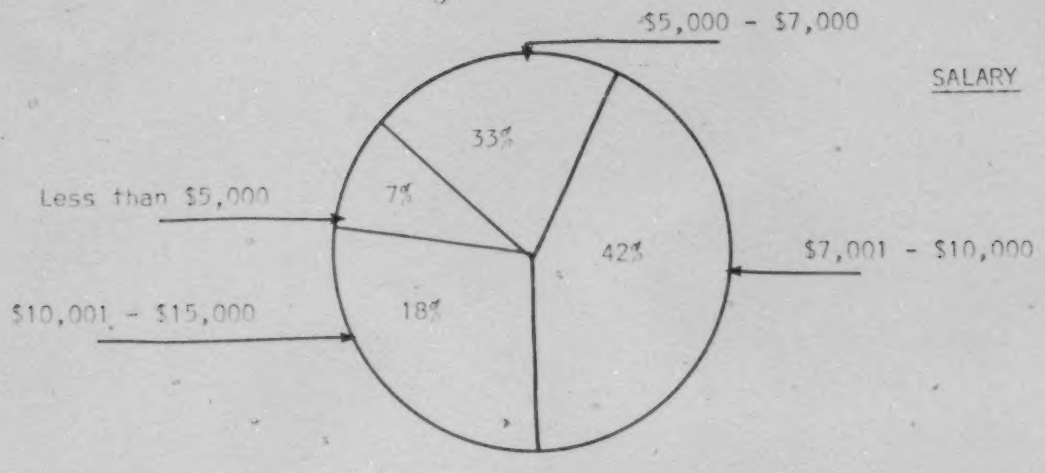
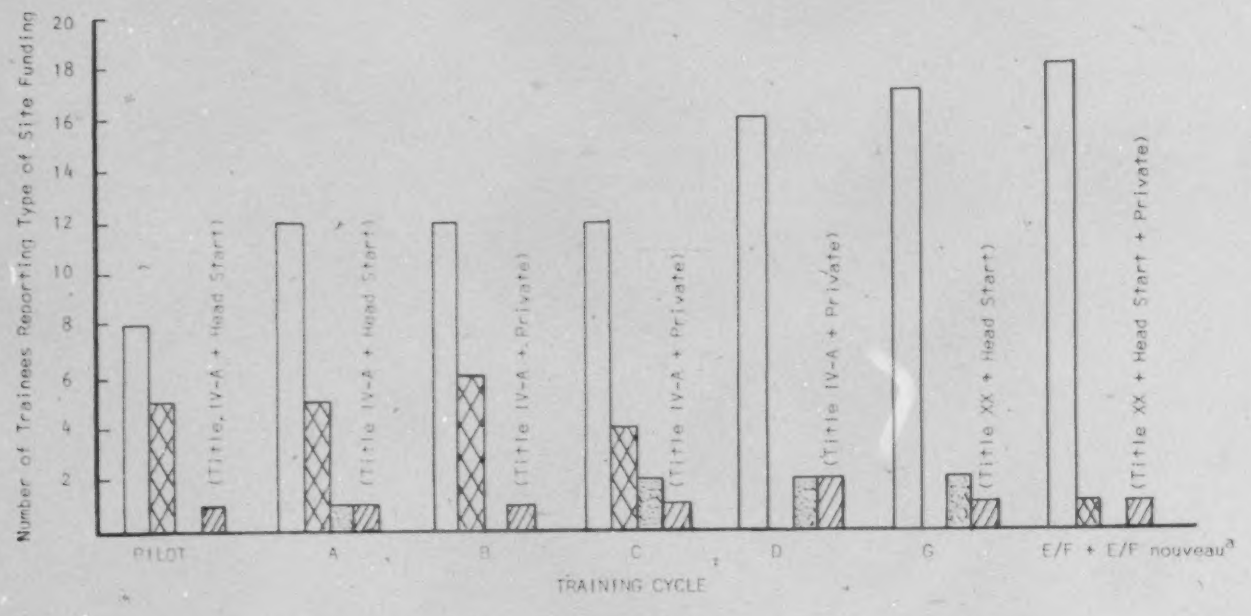


SALARY

Number Responding = 115

The distribution of types of funding represented by trainees in each cycle is shown in Figure 9. More than half the trainees in every cycle represented Title IV-A (or Title XX) programs. Head Start sites represented less than one-third of the trainees in any cycle. Cycle D had none and Cycle G had only one Head Start representative because most of the Head Start sites in the area had participated by the time Cycles D and G entered training. Every cycle had at least one representative of a program which had private funding, although in some cases these same sites also provided some publicly supported care. As in the case of Head Start programs, the arrangement of the cycle composition required some compromise between the needs of a rigorous experimental design and the needs of participating programs to fit the training into their own schedules. Multi-site agencies wanted to phase in the Health Advocate role over a period of a year or less so that annual budgeting and program evaluation schedules could be coordinated with the activities of the Project. Last minute cancellations usually occurred when there were staffing problems at the site. Wherever possible, training slots were filled from a pool of applicants who were matched as closely as possible to represent a particular type of funding and clientele profile. Toward the end of the demonstration period, the pool of potential sites was very small, making it difficult to assure that later cycles were exactly comparable to earlier groups. To some extent, variation in results from cycle to cycle discussed in Section IV may be related to these difficulties.

TYPES OF SITE FUNDING REPORTED BY TRAINEES ON ENROLLMENT INTO TRAINING



Notes: [a]Trainees in Cycle E/F included those who accepted training after the contrast evaluation (E/F) and those who were newly evaluated just prior to training (E/F Nouveau).

[b]Title XX replaced Title IV-A funding in 1975.

Title IV-A (Title XX)[b]
Head Start
Private
Mixed

Figure 9

Composition of cycles by type of clientele served is shown in Figure 10. Although in every cycle the majority of trainees represented sites which served preschoolers, every trainee group included representatives from sites which served infants-toddlers, schoolage children and children with special needs.

CYCLE COMPOSITION BY TYPE OF CLIENTELE SERVED AS REPRESENTED BY TRAINEES

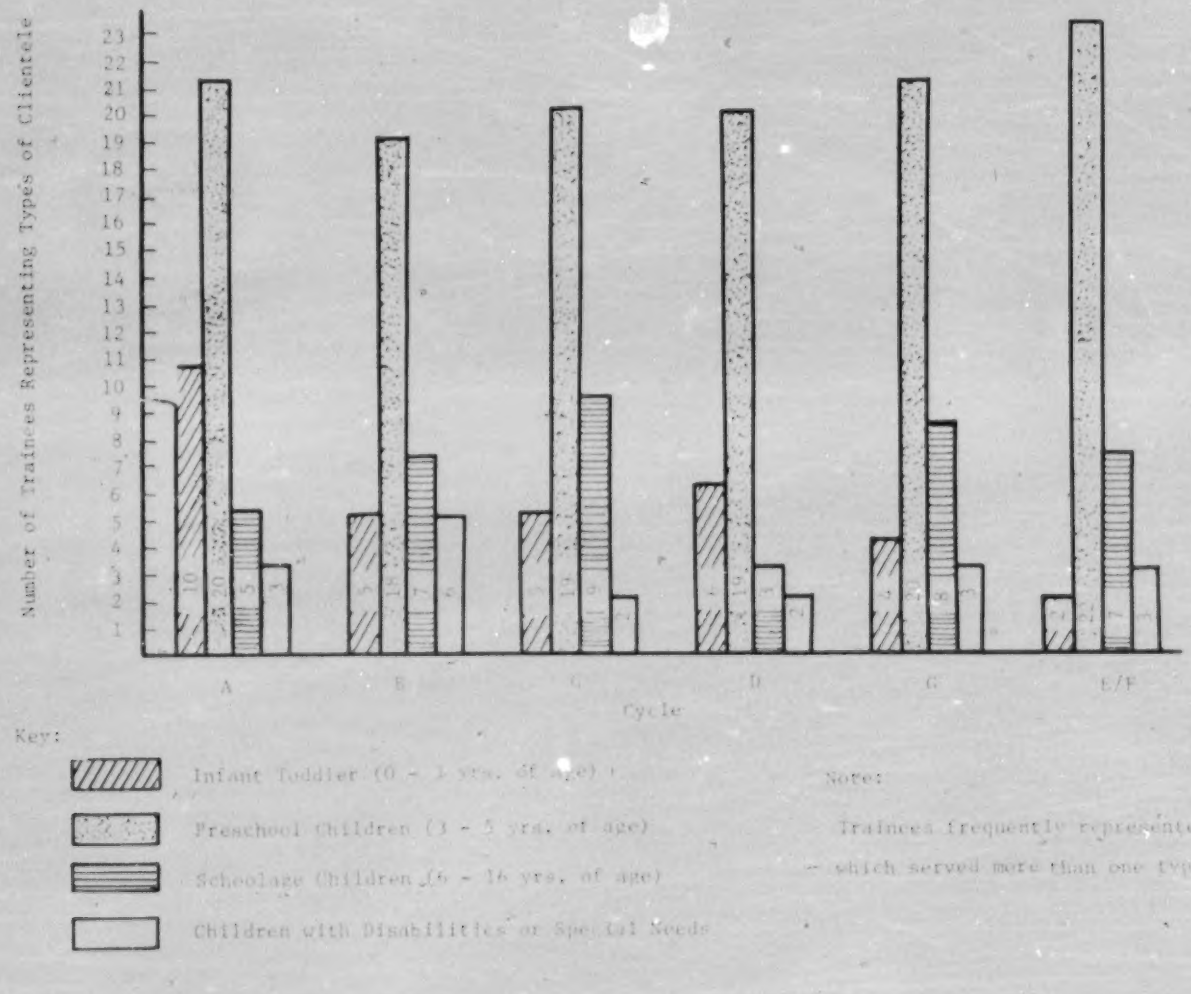


Figure 10

D. DEVELOPMENT OF SITE SPECIFIC TRAINING AND TECHNICAL ASSISTANCE

1. The Training Course

a. Overview of the Curriculum

The basic 72 hour training course was developed during the first year of the demonstration project by the Principal Investigator, a Pediatric Nurse Associate and a Registered Nurse. The primary emphases of the training were to have the trainees:

1. Use advocacy and problem-solving skills to improve the health aspects of their day care program site

2. Identify references and institutional resources for updating factual information on health and safety issues

3. Identify community health providers who could and would provide preventive, diagnostic, and therapeutic health services to the children and adults involved with the day care program.

Although the course curriculum contained a considerable amount of factual material, retrieval, not retention of facts was emphasized. There was a basic structured curriculum, but every effort was made to individualize the training to meet the needs of the trainee and his/her program.

After the Pilot Cycle, the course was taught primarily by the Pediatric Nurse Associate with the support of the Registered Nurse. The course involved extensive participation of guest speakers representing community service agencies and the use of role playing, workshops, demonstrations, modeling, audio-visual presentations, guided and group discussions, lectures, games, independent work, counseling, reading and teach-back techniques.

The course consisted of 12, six hour classroom sessions, attended one day per week by the trainees, but conducted by the trainers twice each week for two groups of approximately 10 trainees. The training site was a day care facility which serves 40 infant-toddlers and preschoolers and 17 schoolage children. Most of the training sessions were conducted in two rooms, but activities sometimes included use of the day care service areas of the building. The training schedule of the cycles overlapped so that Session 12 for each cycle fell between Session 5 and 6 for the following cycle. Although trainees usually attended training sessions on the same day each week, they were permitted to attend the session on the alternate day when their schedules made attendance on their assigned day difficult.

To enhance the transferability of the training experience from one job situation to another, optional registration for three hours of field-based, early childhood education college credit was available to the trainees at Philadelphia Community College. The cost of registration was $5 per trainee and required that the trainers grade all assignments. Except for this fee, no other fees were charged to the trainee or to the day care site for any Project-related activity.

Whether or not the trainee chose to register for the college credits, each Advocate who completed the post-evaluation was eligible for a certificate from the Project which described the content of the activities in which s/he had participated. The certificate was issued to the Advocates to document their experience both to their present employers and to any future employers who were not familiar with the role of a Health Advocate or with the nature of an Advocate's experience with the Project.

In addition to attending the supervisors' workshop, the trainees' supervisor and the programs' local health consultant were invited to attend the afternoon portion of Session 12. This portion of the training was devoted to a workshop on planning for continued health component improvement. The sequence of topics covered in the training course are shown below in Table 1.

TABLE 1

TRAINING SCHEDULE
Training For Health Advocacy in Child Care Programs

Supervisors' Workshop

Session One
- Welcome and Orientation
- Pre-training Data Collection
- Health Advocate Role
- Health Resource File

Session Two
- Health Resource File
- What Is Health Care?
- Individual Health Records

Session Three
- Using Individual Health Records
- Tick Sheet As A Guide
- Health Worksheet
- Inspection Examination

Session Four
- Continuation of Inspection Examination
- Continuation of Records and Forms
- Immunizations
- Medication Administration
- Introduction to Screening Tests

Session Five
- Lead Poisoning
- Hearing

Session Six
- Denver Developmental Screening Test
- Vision Screening
- Safety and Environmental Quality

Session Seven
- Dental Health
- Nutrition
- Mental Health

Session Eight
- Mental Health (Cont'd)
- Review of Advocacy Role
- Signs, Symptoms and Management of Minor Illness
- Organizational Approaches to Health (communication, payment and planning)

Session Nine
- Children With Special Needs

Session Ten
- Transportation
- First Aid
- Disaster Plans
- Health Policies (rough draft critique)

Session Eleven
- Health Advocacy--Meaning and Strategies
- Health Education
- Keeping Up-To-Date
- Use of Health Consultation Services

Session Twelve
- Course Assignment Completion
- Update of Health Resources
- Evaluation of Post Course Health Knowledge and Health Opinions
- Job Description
- Health Component Improvement Plan
- On-Going Reunions and Continuing Education Arrangements

To help the Advocates make changes, the trainers repeatedly encouraged them to use basic management principles in their planning. For example, before attempting any significant change, trainees were urged to communicate with those who would be affected by the changes, those who have expertise in the area needing change and those who have authority to require that the change occur and that it is maintained.

Every trainee had an obligation to practice this management principle every week by initiating a weekly "teach-back" session at his/her own site to share information and ideas for change gathered at that week's health advocacy class. "Teach-back" took a variety of forms: talking for 10 minutes at staff meeting, sending a memo to program staff, posting notices on a special bulletin board, or singling out one person to discuss the information.

In addition, trainees were asked to implement as much change as possible after each class and to maintain a journal in which they recorded the results of their efforts at "teach-back" and other attempts to advocate for change at their programs between sessions. These journals were collected by the trainer at the beginning of each session, read, commented upon and returned to the trainee by the end of the training day so that each trainee could receive personal support and encouragement for his/her efforts. In addition to the one-to-one communication afforded by the journals, the trainers carefully reviewed the relevant pre-training data collected from the trainees and their sites before each session so that individual trainees could be called upon to share the planning behind successful and compliant aspects of their programs.

To encourage the use of health resources rather than memorization of facts, much of the training focused on the distribution and use of resource materials, identification and subsequent contacts with local health and safety authorities, audio-visual presentations of health activities such as toothbrushing and developmental screenings performed in the day care setting, involvement of the trainees in doing rather than just listening. Trainees developed their own health resource filing system to handle the extensive material supplied during the course, but also learned an efficient method by which to collect, store and use health information at their day care program sites. The curriculum favored role playing and simulation of real-life situations which could be replicated by the trainee at his/her own site. For example, trainees were involved in discussion of logical approaches to first aid for injuries which are likely to occur in the day care setting. They then practiced the methods on each other, simulating the situation from their own day care experiences. Next, they developed a list of those items which should be included in a first aid kit and subsequently assembled these materials, (from supplies collected by the trainers) to carry back to their own day care site. The entire exercise took little more than two hours, a practical investment which could be replicated over the course of several staff meetings at each trainee's site. The health expertise required by the exercise was provided by the trainers through discussion and guidance during the activity. Many trainees have successfully replicated this activity with the support of training plans taken from the HAT Training Manual, calling on local health consultants for health professional expertise.

b. The HAT Training Manual

The HAT Training Manual was developed during the pilot period and refined throughout the course of the Project. Refinements represented efforts to make the manual useful to others. No significant changes were made in the training during the demonstration period.

The HAT Training Manual contains training plans for 12, six hour sessions and reference materials used for the course. The manual is expected to be helpful to anyone who wants to help staff of day care programs to promote health and prevent or minimize illness and injury in young children.

The manual can be used in several ways:

- As a guide to a 72 hour training course
- As an aid in planning short in-service training sessions on individual topics such as dental hygiene, first aid, management of minor illness, transportation safety
- As a source of informational handouts and forms which help to organize various types of day care procedures
- As a source of reference materials to provide a greater depth of information than is provided in the training manual itself.

To minimize the amount of preparation required by both health and child care providers who want to use the manual for in-service health training, the manual contains nearly all the materials necessary for any of its potential uses. In the beginning chapters, the manual orients the reader to health advocacy concepts. A training plan for each session follows, complete with an outline of each training activity consisting of:

- Behavioral objectives to be accomplished by the activity
- Basic health, advocacy or management concepts behind the activity
- Step-by-step methods for performing the activity
- The time the activity usually requires
- Materials and equipment needed to perform the activity
- What the trainers must do to prepare for the activity
- What the trainees must do to prepare for the activity
- Methods for evaluating whether or not the behavioral objectives of the activity were accomplished.

At the beginning of the training plan for each session is an agenda which can be reproduced for the trainees involved in the activity. Following each session's training plan is a list of references and an appendix of materials which can also be reproduced for use in the training activity. The training plans for some sessions include an additional appendix which contains materials trainers can use for more in-depth preparation of the training activity.

At this writing, the HAT Training Manual is available only from the Principal Investigator, but commercial publication is being sought.

c. Trainer Reflections on Key Features of the 12 Session Training Course

Several key features can be identified which may have affected the outcome of the training. Since training cycles were set up to consist of heterogeneous groups of trainees from privately and publicly funded centers and family day care homes, from infant-toddler, preschool, schoolage and special needs programs, trainees were able to bring divergent experiences from their individual programs to the sessions so that a broad spectrum of ideas could be addressed by the training. Several Advocates who changed positions and who are now employed in a different day care setting have commented to HAT staff that this feature has helped them adjust to their new situations.

Another key feature was the effort to gain the support of each trainee's supervisor before the trainee began the course. Clear understanding and endorsement of the course objectives and procedures by the supervisors went a long way toward preventing frustrating resistance to implementation of classroom-gained knowledge and skills.

Scheduling the training sessions so that they would be compatible with the day care program calendar was also extremely important. For example, if the trainee was the social worker at the site, and training occurred during a time when new children were being enrolled, it was difficult for the trainee to attend training, manage the assignments of the course and also fulfill other job responsibilities. Training sessions held during the summer months had a higher absentee rate than those conducted in the fall and winter since some sessions conflicted with trainee vacation plans.

An important objective of the training design was to individualize the training activities to meet the needs of the trainee and his/her program. Relevant portions of the data collected in pre-training evaluation of the site and of the trainee's health knowledge were reviewed prior to each training session. This pre-session review made it possible for the trainer to use each trainee's experience and knowledge to teach others and to encourage each trainee to seek help in areas of weakness. Trainees were encouraged to initiate this sharing among themselves. At the opening of the first training session, after the trainers described their background and expectations of the training to the trainees, the trainees were asked to describe their backgrounds and experience to their co-trainees. This procedure helped trainees identify similarities, differences and potentially supportive linkages with the trainers and with other trainees.

Another way in which training was individualized was through the trainer's responses to written journal entries submitted by the trainees each week. Journals served as a vehicle for one-to-one, trainer-trainee contact which significantly enhanced the trainer's ability to be responsive to each trainee's needs.

Group size was also critical to the success of training activities. When fewer than six trainees attended a session, or when more than 12 came on one day, there was a noticeable loss of participation and enthusiasm for the training experience. Group size varied when trainees were absent, when they rearranged their training day because of personal schedule conflicts and when enrolled trainees dropped the course after training had begun.

Attending the training required significant travel and workday adjustments for most trainees, but attendance rates were high. As shown in Figure 11, the mean per session per cycle attendance for Cycles A, B, C, D, G and E/F was 17.10 trainees. This represents an overall attendance rate of 88% of enrolled trainees. (See the end of this Section for cycle-by-cycle tabulation of this data.) There was no trainer-imposed penalty or reporting of absences to supervisors. Absence from individual sessions increased steadily from Session 1 to Session 12 of the course. Since trainees were permitted to make-up missed sessions in the next cycle's training, attendance calculations include sessions which were missed, but which were subsequently made-up by the trainees.

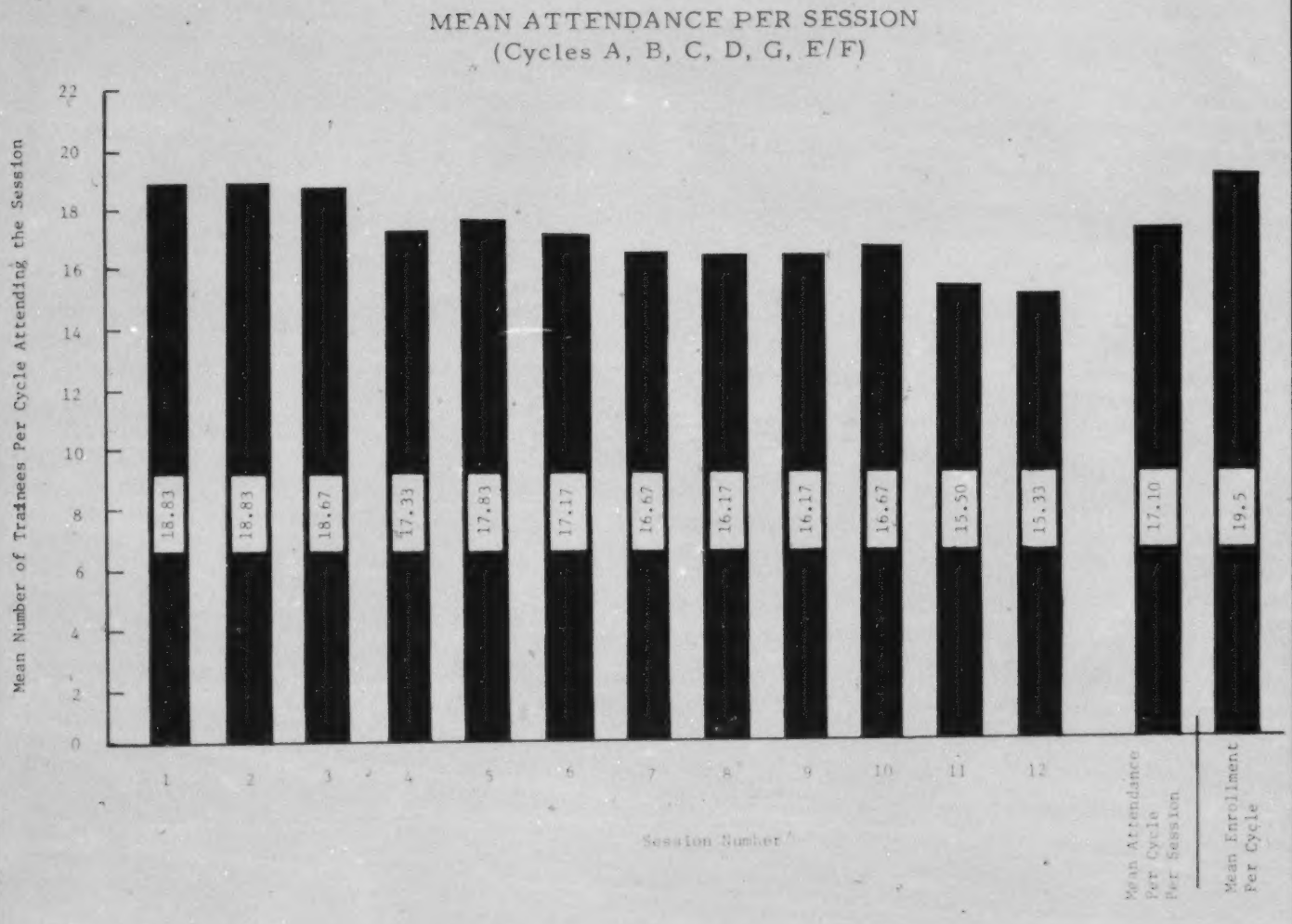


Figure 11

As shown in Table 2, tardiness was a consistent problem.

TABLE 2

TARDINESS

Cycle	# Episodes[a]	Trainees Ever Late	
		#	%[b]
A	21	12	63%
B	12	5	29%
C	7	4	22%
D	17	9	60%
G	26	6	30%
E/F	45	15	79%
	21.3	51/123	47%

[a]Lateness is defined as arrival 15 minutes or more after the stated starting time for a session (9:00 a.m.).
[b]Number of trainees ever late ÷ number of trainees completing the course.

During the training course, each trainee was asked to submit five standard assignments: (1) a Health Resource File containing useful written materials, phone numbers and addresses; (2) a set of health policies for use at the day care site; (3) a weekly journal entry; (4) a day care menu for a two week period; and (5) a revised job description. Figure 12 shows assignment completion rates. The majority of the trainees completed four of the five assignments. The one assignment completed less often than the others was the drafting of a revised job description. This is probably due to the difficulty of this task. See the end of this Section for tabulated cycle by cycle data.)

COURSE RELATED BEHAVIORS: COMPLETION OF ASSIGNMENTS

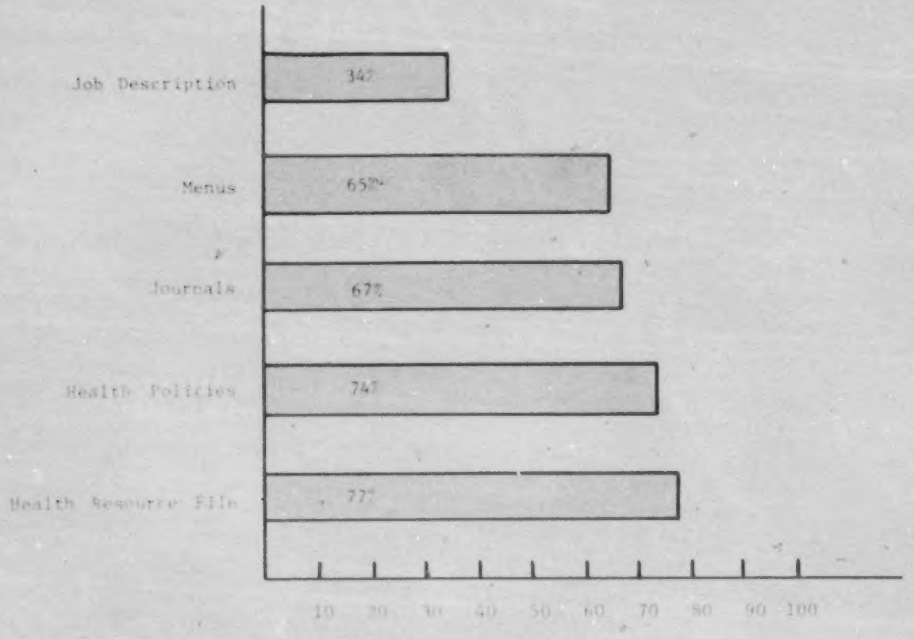


Figure 12

d. Trainee Evaluations of Individual Training Sessions

Each trainee was asked to record his/her evaluation of each training session on a form called the "Group Activity Rating Form". This form included four questions. The first two questions were "How interesting was it?" and "How helpful was it?" to which the trainee could respond by circling "very", "some", "little" or "not at all". The second two questions on the form were open-ended: "What do you think might have made the experience better for you?" and "What contributions did you make to the activity that were important to you?". The trainee's responses to this form were classified using the following criteria:

Favorable: The respondant circled "very" or "some" in response to the first two questions on the form. For the second two questions, the respondant offered suggestions on improving the experience which were basically constructive and indicated satisfaction with the session content and presentation;

Or

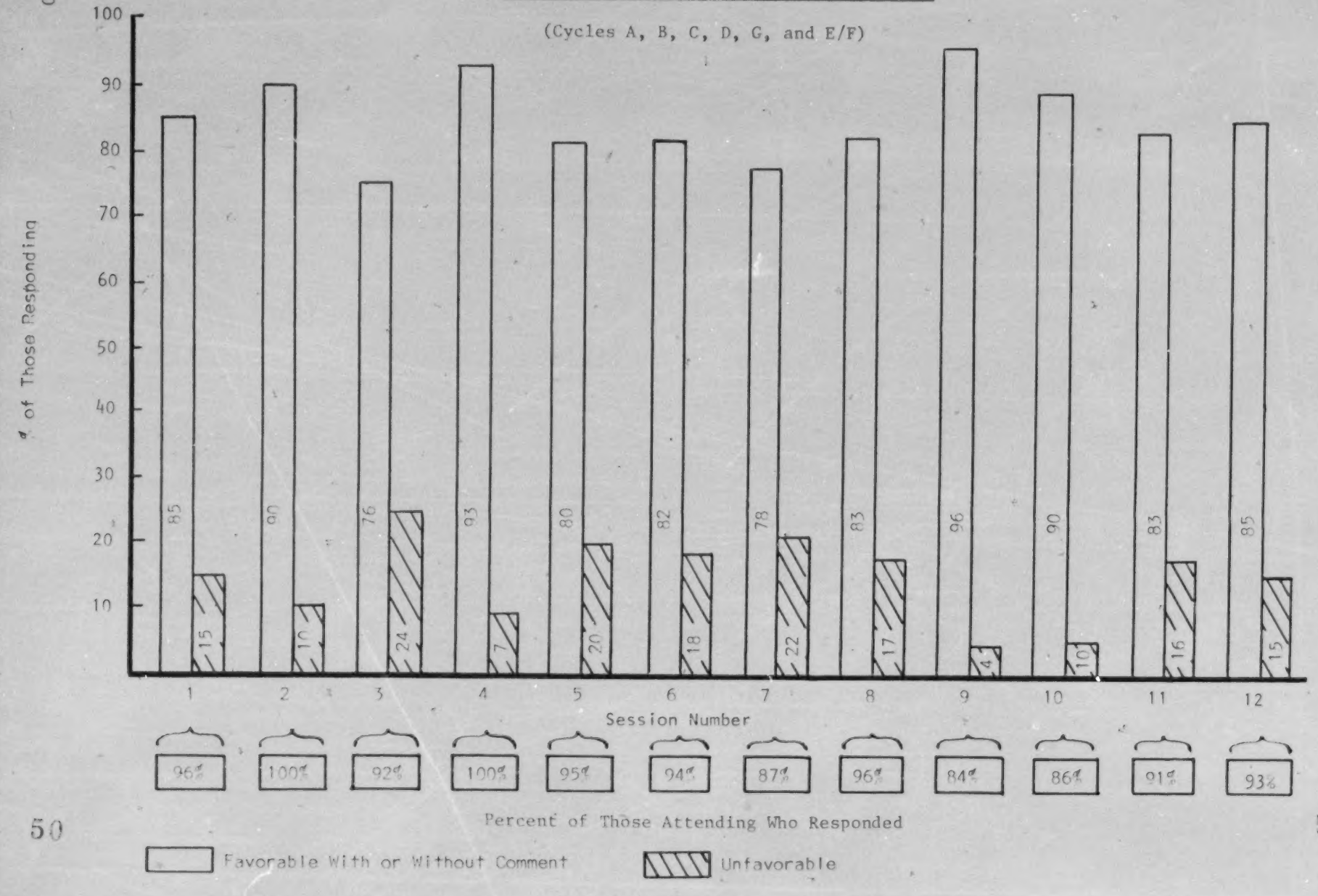
The respondant circled "very" or "some" in response to the first two questions on the form and did not respond to the second two questions.

Unfavorable: The respondant circled "little" or "not at all" for the first two questions and did not respond to the second two questions, or the respondant circled "very" or "some" for the first two questions and offered comments indicating some type of dissatisfaction with the session content or presentation in response to the second two questions.

A summary of the responses recorded on the Group Activity Rating Forms for all training cycles is shown in Figure 13. Between 84% and 100% of the trainees attending the sessions completed the form. The data suggest that although there is some variation in trainee evaluation of different sessions, overall, the trainees had a positive view of every session. Negative comments were most often about the requirement that trainees eat the food served to the day care children at the training site or about the volume of material covered in the session.

TRAINEE'S EVALUATION OF TRAINING SESSIONS

(Cycles A, B, C, D, G, and E/F)



2. Development of a HAT Consultation Service

A HAT Consultation Service was established to provide assistance to day care staff on specific health problems at their programs. The service was publicized through a city-wide day care newsletter, announcements to trainees, and announcements made at Region-wide day care meetings. Staff of sites whose trainees could not be accommodated because of cycle composition constraints were encouraged to call the HAT Project for health advice as needed. Each call was documented so that the utilization of the consultation service could be assessed.

A total of 209 requests were received between July, 1973 and July, 1976. Seven percent of the requests were made by day care staff or affiliated agency staff prior to training the site's staff member; 22% of the requests came from staff of agencies which were related to participating day care programs either administratively or through referral relationships, but who were not actually workers at the day care site. The remaining requests came from Advocates after training. Advocates used the consultation service as an "umbilical cord" for health advice and materials. The nature of the requests made of the consultation service can be divided into three main categories: technical assistance, requests for resource information and consultation on problems requiring decisions on the part of the caller. As shown in Figure 14, the majority of the requests were for resource information, often for specific materials.

USE OF HAT CONSULTATION SERVICE 1973 TO 1976

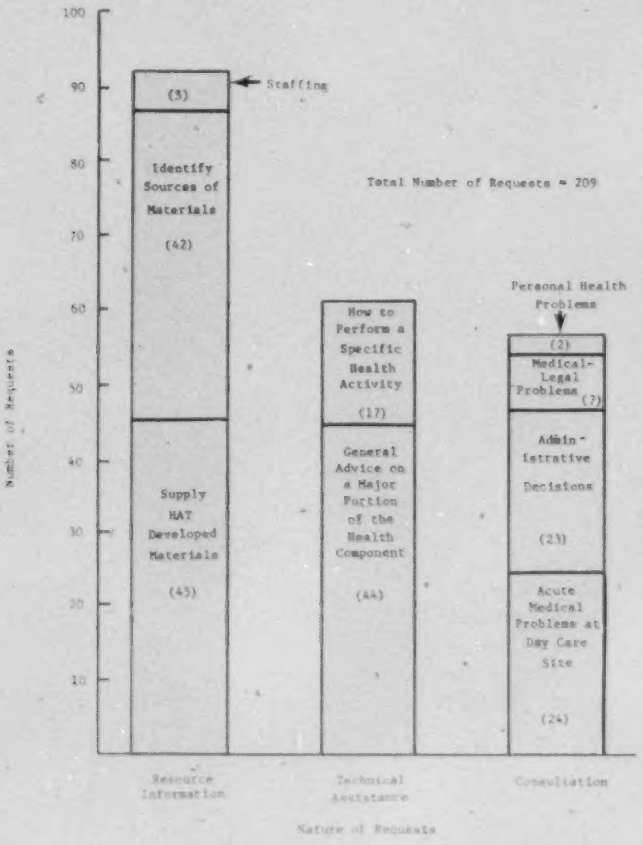


Figure 14

3. On-Site Retraining Visits (OSRV)

On-Site Retraining Visits began in September, 1975 after computer scoring program revisions were made. The computer program tabulated items on the HSCC into scores for each aspect of the health component. Scores were interpreted to day care sites as a means of stimulating self-improvement planning. A protocol for the preparation and conduct of the visits was developed along with suitable forms for use by HAT and day care site staffs. When computer-scored data for a site became available, the site's Health Advocate was invited to arrange a meeting to include him/herself, the site's supervisor, the site's local health consultant, any appropriate central administrative staff (if the site was part of a large agency) and two members of the HAT staff. Since most of the Health Advocates were not health professionals, they hesitated to invite local health providers to the meeting because they expected to be refused. In most cases, the health providers did come and always contributed significantly to the meeting. In several instances, a health provider discovered that the day care program was serving children whom the provider had been seeking for follow-up care. Because the children were at the day care site and the parents working during the day, the children's follow-up care had not been completed. Identification of the day care program as an access point to the family enabled the health provider and the day care staff to work with parents to obtain the services needed for the children.

For sites which were parts of multi-site agencies, the OSRV provided an opportunity for sharing between components and across administrative levels. The meeting often brought supervisors of different components to the site to meet with site staff for the first time. Commonly, communication in large agencies is handled by written memo from upper level administrators to site staff who are given little opportunity for input into decisions which affect them. Site staff were often surprised by the flexibility and concern with which their problems were received by their off-site supervisors. Before the OSRV, many site staff believed that they could have no input into modifying centrally developed policies and procedures which they found impractical. Most OSRV's resulted in supervisor commitments to support site staff in initiating changes designed to correct problems identified by the HAT assessments. The meeting usually lasted 2 hours and was most often scheduled in the afternoon during the children's naptime.

The OSRV meetings were scheduled at the convenience of the day care program participants as soon as the pre-post HSCC data had been coded, keypunched and computer scored. Since computer scoring did not begin until September, 1975, the first OSRV's were based on post-training data which had been collected as long as one year before the meeting. The data for sites with organized central agency structures were presented as a group at the request of the central agency administrators. One multi-site day care program asked to have the data presented two ways: first to central administrators and then in individual site-by-site feedback with site supervisors.

The principal HAT staff members involved in the OSRV's were the Health Trainer, who presented the data to the other participants at the meeting, and the Field Health Trainer who recorded the commitments, plans for improvement and evaluated the OSRV session.

According to the OSRV protocol, the areas discussed were identified by the Health Trainer as the three major areas in which the program's computer processed HSCC scores were the highest and the five areas where the scores were the lowest. The raw data were examined in these areas to determine the specific

items which caused the scores to be high or low. As a follow-up to the OSRV, a copy of the meeting record was returned to the site to serve as a reminder to the other participants at the OSRV of their commitments.

In April, 1976, the costs for the OSRV procedure were assumed by the Pennsylvania Department of Public Welfare for Title XX programs. By September, 1976, 54 OSRV meetings had been completed at individual day care sites, three central administrative or grouped site feedback meetings covering data from the large multi-site agencies had been held (some of which also had individual OSRV meetings), 29 sites had pending appointments for OSRV's, and 31 sites had received their results by mail at their request because of difficulties in arranging a meeting time when all participants could attend. Of the 54 completed individual site OSRV's, seven involved sites where the program no longer had a Health Advocate. Fifty three (53) of the 54 sites used the OSRV to make specific plans of action; only one site invited a parent to the OSRV (although many programs identified parents as needing to be involved in the solution of problems discussed).

Table 3 tabulates the results of the 54 OSRV's described above. Dental care was the most frequently discussed problem area. Emergency evacuation and disaster plans, health services, health records, health policies and procedures were the next most commonly discussed. The plans made included a combination of immediate corrective action and further planning. Most often, the Advocate and/or other site staff were involved in problem-solving. Outside resource people were felt to be needed much less often.

As a result of the OSRV, 35 different types of material or references for sources of material were requested. By far, the most popular request was for the Tick Sheet and Tick Sheet Key (63 requests). The Tick Sheet is a HAT prepared summary of currently recommended routine preventive health services and normally expected results of screening tests for children. In some cases, requests for the Tick Sheet were made by health consultants present at the OSRV as well as day care program staff. The next most frequently requested item was the Health Worksheet and its Key (50 requests). The Health Worksheet is a modification of the Head Start Health Services Bookkeeping System which day care program personnel use to identify and follow-up on children's health service needs. (The Tick Sheet is at the end of this Section. The Tick Sheet Key and the Health Worksheet are available from the Principal Investigator.) The popularity of these two forms may be related to the fact that of the problems discussed with programs at OSRV's, screening, medical evaluation and treatment services and health record content were most frequently involved. Solution of these problems requires awareness of current recommendations and application of the recommendations to the health records of individual children.

4. HAT As A Continuing Service Agency

Upon completion of the demonstration project, the HAT Project was awarded a contract from the Department of Public Welfare to continue to provide training and technical assistance to Title XX day care sites in the Southeastern Region of Pennsylvania. The basic 12 session course is now held once a year. Trainees are enrolled from sites where there has been staff turnover, or from newly opened sites. All other sites are offered the OSRV after they receive their annual evaluation by the Department of Public Welfare monitoring staff who use the modified version of the Health Standards Compliance Checklist (HSCC-M). A library of reference and training materials has also been developed for use by Health Advocates and HAT trainers. In addition to the numerical data presented in this report, the recognition of the Project for continued support as a service program by DPW is viewed by the Project staff as a significant measure of success.

THE RESULTS OF ON-SITE RETRAINING VISITS AS OF SEPTEMBER, 1976

	Problem Area of the Health Component Discussed in 54 OSRV														
	Dental Care	Emergency Evacuation & Disaster Plans	Health Services Medical Eval. & Treatment	Health Records	Health Policies & Procedures	Health Services Screening	External Planning	First Aid	Environmental Quality & Safety	Health Education	Internal Planning & Administration	Nutrition	Staff Health	Routine Transportation	Special Needs Children
Number of Instances In Which Problem Was Discussed	36	31	30	25	25	24	23	18	15	14	14	13	11	9	8
Plans Made															
Immediate Corrective Action By Staff	10	19	8	9	4	8	11	8	8	0	6	3	5	3	4
Further Planning By Staff	26	12	22	16	21	16	22	10	7	14	8	10	6	6	4
Individuals Involved In OSRV Plans															
Outside Resource Person															
-Represented at OSRV	4	0	7	4	5	5	7	4	2	5	5	1	4	0	0
-Need to Contact	2	4	4	4	1	4	6	1	2	5	1	1	0	2	2
Advocate	15	17	19	16	14	11	14	12	10	10	3	2	5	5	5
Other Staff Involved in Problem-Solving	21	17	17	16	19	14	11	12	7	5	11	9	9	4	6
Parents															
-Represented at OSRV	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
-Already Involved	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
-To Become Involved	2	0	0	0	3	0	5	0	0	1	0	2	0	1	0

55

56

E. IDENTIFICATION OF COMMUNITY HEALTH SERVICE AND INFORMATION RESOURCES AND DEVELOPMENT OF ONGOING SUPPORT TO HELP TRAINED DAY CARE PERSONNEL CARRY OUT HEALTH RELATED FUNCTIONS

This section describes activities which evolved as a result of the Project's implementation. Much of the information for this section was derived form the HAT Process Log previously described.

1. Health Consultant Registry

In 1974, the Project staff began to alert local day care program health consultants to day care health issues so that they could provide helpful advice to day care sites. A state-wide Health Consultant Registry was started by placing requests in Pennsylvania medical and day care newsletters for names of health consultants who were relating to day care programs or who wished to be identified to day care programs which were seeking local health assistance. The Registry was used by the Project to disseminate materials and articles to the consultants who were interested in becoming involved or those who were already involved in day care. As of September, 1976 the Registry listed 37 health consultants of whom 22 are physicians, 12 are nurses and 3 are other types of health professionals. With the support of the Pennsylvania Chapter of the American Academy of Pediatrics, the Consultant Registry will be an ongoing resource to day care programs in Pennsylvania.

2. HAT Alumni Association and HAT Newsletter

Less than one year after the first training session began, trainees who had completed Session 12 (Pilot, Cycles A and B) joined with the trainees in Cycle C in a request of HAT staff to support the organization of a Health Advocate Alumni Association. The Advocates explained that they felt a need for mutual support after the termination of training and for a regularly scheduled opportunity to call upon community health resource representatives to provide up-to-date health information to Health Advocates as a group.

At their first meeting, officers were elected and a decision was made by the group to develop a Newsletter to share ideas and health news with all Advocates, even those who could not attend the Alumni meetings. Until the close of the demonstration phase of the Project, the meetings and Newsletter were organized on a quarterly basis by Health Advocates with staff support from the Project. HAT Alumni meetings became the occasion at which HAT Certificates were awarded to the Advocates who completed the Project activity sequence as well as problem-raising and problem-solving sessions. Community health representatives who were guest speakers at these meetings included the community educator of the regional office of the U.S. Consumer Product Safety Commission, the coordinator of the EPSDT Program in the Southeastern Region of Pennsylvania and the director of the Philadelphia MH/MR Program.

3. HAT's Efforts to Obtain Administrative Support for Health Advocate Role Changes

Every program which participated in HAT was confronted with the competition between new health advocacy and other program responsibilities. When the support of day care administrators and staff was lacking, the integration of health advocacy with other program roles was a frustrating experience. Although the Supervisors' Workshop emphasized to all supervisors the need to provide designated time for

the trainees to perform their new tasks, administrative support seemed to be easier to obtain in independent or small multi-site agencies. Advocates from the two large multi-site agencies frequently complained of being frustrated and disillusioned by the lack of support from their multi-level bureaucracies.

4. Development and Function of the Joint Health Planning Committee

Early in the demonstration, the Joint Health Planning Committee was developed to act as an ad hoc advisory and information sharing body whose members represented the HAT Project and health staff from the Philadelphia School District. Committee membership never exceeded 10. The group consisted of task-oriented health-concerned individuals involved in the day-to-day operation of children's programs. Because the membership of the Committee was both knowledgeable and influential, decisions made by the group could often be implemented through several channels simultaneously.

In 1974, this opportunity to influence decision-making was used in a successful effort to have the Secretary of the Pennsylvania Department of Public Welfare rescind an order excluding health component costs as admissable for public funding support. In January, 1975, the Committee addressed the issue of tuberculosis screening requirements for day care staff to the Philadelphia Health Department. A policy statement was obtained from the Health Department indicating their agreement to provide needed tuberculin screening tests and any appropriate chest x-ray follow-up procedures. In August, 1975, the Committee successfully negotiated to obtain the benefits of the Department of Public Welfare Title XIX School Medical Assistance Program for all day care children. The School Medical Assistance Program provides supplemental benefits to individuals who are eligible for limited medical assistance benefits under the usual program.

Unfortunately, in October, 1975, the Joint Health Planning Committee was disbanded when several of its key members vacated their positions and no replacements were hired by their agencies.

F. DISSEMINATION OF PROJECT FINDINGS

1. The Principal Investigator's Involvement in State Advisory Committee.

In 1973, the Principal Investigator was appointed to the Day Care Advisory Committee of the Pennsylvania Department of Public Welfare. As a member of that Committee, she was assigned to the sub-committee whose task was to recommend revisions for Pennsylvania's day care regulations. Two significant outcomes emmanated from this assignment: first, the Principal Investigator was able to channel the content of recommended health standards into regulation proposals being offered to the state; second, the Principal Investigator was able to influence the language of state-wide policy statements on health-related issues.

The Principal Investigator was also appointed by the Chairman of the Pennsylvania Chapter of the American Academy of Pediatrics as Chairman of the Pennsylvania AAP Day Care Committee. This position facilitated the identification of health professionals who might potentially become interested in acting as health consultants for day care programs.

2. Development of a Concept Paper for the Revision of the Federal Interagency Day Care Requirements

In December, 1975, the Principal Investigator was asked to develop a concept paper on health and safety in day care as part of a congressionally mandated study of the appropriateness of the 1968 Federal Interagency Day Care Requirements. In collaboration with Peggy Daly Pizzo, a day care consultant and writer, over 375 references from the scientific and child welfare literature were reviewed and 131 day care and health experts were consulted to develop the paper. The final manuscript was submitted to William Prosser, the Director of the Office of Planning and Evaluation for the Assistant Secretary of Health, Education and Welfare in September, 1976. This document contained preliminary findings from the HAT Project. The paper described health and safety risks in day care, identified day care program characteristics which would help to prevent or minimize these risks, described the current state of health and safety in United States day care, made recommendations for federal action and discussed the impact of proposed actions.

3. Costs

It is important to analyze the costs of carrying out the training and evaluation activities developed by this demonstration project. Unit costs can be developed by multiplying the time required for a given activity by the hourly wage of the person(s) performing that activity. Caution must be exercised in applying such unit costs to other settings. The training and evaluation were completed within the context of a research effort. Many hours of planning and development which are not easily assigned to unit costs would be required to transfer the training and evaluation activities to other settings. In this sense, the following unit costs should be considered minimal estimates of those to be anticipated in replications of HAT.

In HAT, the cost of completing one comprehensive health and safety assessment (HSCC) including instrument preparation, data collection and data processing is $104 per day care site. The cost of training one Health Advocate including assembly of materials, preparation and teaching time is another $104 per day care site.

The cost of training is given per site rather than per trainee. The relation of these two will depend on the proportion of trainees who represent multiple sites. The larger the proportion, the more economical the training program per site. In this demonstration project, 11% of the trainees represented multiple sites. Only the representatives of the three family day care programs represented more than two sites.

The total cost of the HAT Project exceeds the sum of the unit costs of training and evaluation of participating sites. HAT Project costs include the cost of initial project development, conduct of the extensive evaluation design, reporting, service diffusion and community impact activities described elsewhere in this report.

The cost of the entire HAT Project over the three year demonstration period is reflected in the following summary of the funding of the Project between 1973 and 1976.

Budget Category	1973-1974	1974-1975	1975-1976
Personnel	$63,690.	$96,368.	$114,523.
Consultants	1,000.	5,000.	5,000.
Supplies	1,475.	1,600.	1,000.
Equipment	1,500.	1,080.	300.
Travel	945.	1,425.	1,000.
Rent	8,500.	8,500.	4,000.
Other (Printing, Contracts, Postage, Repairs, Phone, Misc.)	600.	840.	7,550.
Data Processing	600.	1,500.	1,000.
Indirect Costs	9,719.	14,455.	16,872.
TOTALS	$88,029	$130,768.	$151,245.
GRAND TOTAL For Three Year Demonstration Period =			$370,042.

4. HAT Staff

The HAT staff consisted of the Principal Investigator, the Research Consultant, the Health Trainer, the Field Health Trainer, two Field Health Evaluators, an Administrative Secretary (who later assumed more of a Project Administrator role) and a Secretary. Staff meetings were held every other week throughout the course of the demonstration project. Although there was some staff turnover related to personal growth opportunities, on the whole, the three year demonstration was sustained by loyalty and devotion to the Project's goal of each and every member of the staff.

5. HAT Project Publications and Presentations

Over the three year demonstration period, the activities of the Project have been reported in seven (7) publications and nineteen (19) presentations listed in Section V. of this report.

CYCLE BY CYCLE DATA FOR FIGURE 5

COURSE COMPLETION

Cycle	Number of Trainees Enrolled	Number of Trainees Who Dropped By Session 2	Number of Trainees Who Dropped Between Session 2 - 12	Trainees Completing HAT Course	
				#	%
Pilot	14	0	0	14	100%
A	19	0	0	19	100%
B	19	2	0	17	89%
C	19	0	1	18	95%
D	20	2	3	15	75%
G	20	0	0	20	100%
E/F	20	0	1	19	95%
$\bar{X}$ For Cycles A, B, C, D, G, E/F	19.5	.67	.83	18	92%
Total	131	4	5	122	93%

CYCLE BY CYCLE DATA FOR FIGURE 11

SESSION ATTENDANCE
(Cycles A - E/F)

Session No.	A	B	C	D	G	E/F	Total	$\bar{X}$/Cycle
1	18	18	19	20	20	18	113	18.83
2	18	18	18	19	20	20	113	18.83
3	19	18	18	18	20	19	112	18.67
4	16	16	17	18	19	18	104	17.33
5	18	18	19	14	19	19	107	17.83
6	15	18	18	17	19	16	103	17.17
7	18	17	15	13	20	17	100	16.67
8	17	17	14	14	20	15	97	16.17
9	17	17	15	12	18	18	97	16.17
10	15	15	19	15	18	18	100	16.67
11	16	17	15	13	19	13	93	15.50
12	16	14	17	14	18	13	92	15.33
Total Attendance	203	203	204	187	230	204	1,231	
$\bar{X}$/Session Attendance	16.92	16.92	17.00	15.58	19.16	17.00		17.10
Enrollment	19	19	19	20	20	20	117	19.50

CYCLE BY CYCLE DATA FOR FIGURE 12

COMPLETION OF ASSIGNMENTS OF THOSE COMPLETING THE COURSE

Cycle	Percent Completed[a]				
	Health Resource File	Journals[b]	Menus	Health Policies	Job Descriptions
Pilot	NR*	NR	NR	57%	NR
A	74%	74%	58%	74%	16%
B	65%	66%	65%	65%	47%
C	78%	62%	56%	89%	50%
D	87%	68%	73%	80%	53%
G	85%	89%	78%	80%	5%
E/F	74%	52%	63%	74%	42%
$\overline{X}$	77%	67%	65%	74%	34%

[a]Advocates completing the assignment of those Advocates who completed the course.

[b]Assignment given on 11 of 12 sessions, checked at the beginning of each session attended. Data is corrected for absences.

*Not Recorded

Developed by:
THE HEALTH ADVOCACY TRAINING PROJECT

THE MEDICAL COLLEGE OF PENNSYLVANIA
3300 Henry Avenue
Philadelphia, Pa. 19129

A GUIDE TO ROUTINE HEALTH SUPERVISION

(Tick Sheet)

PROGRAM NAME

PROGRAM ADDRESS

	HEALTH ASSESSMENT PROCEDURE	AGE: 2–6 WKS.	2–4 MONTHS	5–7 MONTHS	9–12 MONTHS	13–16 MONTHS	17–20 MONTHS	22–25 MONTHS	27–30 MONTHS	3–4 YEARS	5–6 YEARS	8–9 YEARS	11–12 YEARS	13–15 YEARS	16–21 YEARS
	HISTORY / PHYSICAL EXAM														
SCREENING	GROWTH ASSESSMENT														
SCREENING	VISION	**	**	**							or				
SCREENING	SPEECH AND HEARING			**		**					or				
SCREENING	URINALYSIS (ALL) Urine culture (Girls)														
SCREENING	TUBERCULIN							p.r.n.			p.r.n.		p.r.n.		p.r.n.
SCREENING / BLOOD	PKU														
SCREENING / BLOOD	HEMOGLOBIN / HEMATOCRIT										or				
SCREENING / BLOOD	SICKLE, G6PD			o										o	
SCREENING / BLOOD	LEAD						o		p.r.n.						
SCREENING	DEVELOPMENTAL or SCHOOL PERFORMANCE														
	DISCUSSION and COUNSELING														
	DENTAL ASSESSMENT	**	**	**	**	**	**	**	**						
IMMUNIZATION	DPT														
IMMUNIZATION	POLIO														
IMMUNIZATION	MEASLES (Rubeola) / GERMAN MEASLES (Rubella)											o			
IMMUNIZATION	MUMPS											o			
IMMUNIZATION	Td														
	E.P.S.D.T. Screen #	1	2	3	4		5	6	7		8	9	10	11	

SYMBOLS

- ☐ To be performed
- o Where appropriate
- p.r.n. As indicated by liklihood of exposure
- ** Inspection, Observation & Report
- or Indicates that the procedure may be done at one of the visits crossed by the symbol.

NOTES:
1. See Tick Sheet Key and References for explanation of procedures listed, for normally expected results and for listing of sources used.
2. If a child first comes under care at any point in the schedule, or if any items were not performed at the suggested age, the child should receive all the services needed to be brought up to date as soon as possible.
3. The Tick Sheet may be copied with source reference retained.
4. The Health Advocacy Training Project was funded by HEW Grant OCD CB-491.

10/75

SECTION III
INSTRUMENTS

SECTION III

INSTRUMENTS

A. APPLICATION FOR HEALTH ADVOCACY TRAINING

The application is a one page, self-administered questionnaire which identifies the program applying for Health Advocacy Training and describes the person selected by the program for participation in the training activities. The application:

1. furnished identifying information required for continuing contact with the program.

2. identified types of programs by funding sources and by types of clientele served. This information was used in determining the composition of training groups for each cycle.

3. provided information concerning the trainee which was used descriptively in a summary of the characteristics of Advocates trained.

The data collected by this instrument were manually tabulated.

B. HEALTH STANDARDS COMPLIANCE CHECKLIST (HSCC)

1. Instrument Design

The HSCC is a questionnaire and observation recording form designed to examine the health component of a child care program in detail. The HSCC is structured into four sections. The first section consists of an interview questionnaire, the second a set of self-administered forms, the third observations made of the site and the fourth an audit of children's medical records.

The interview questionnaire consists of 270 items on the health component of the program. There are two types of items: pre-coded and open-ended. The content of interview questions is broad and varied. The first part of the interview is a complete program description covering the type of program, funding source, number of children by age group and ethnic identity, enrollment, attendance and hours per day that the program is in operation. The remainder examines the current status of various aspects of the program's health component, e.g., outside personnel who participate in the health component, provisions for children with disabilities, health services provided or arranged such as screening tests, immunizations, medical evaluation and treatment services, maintenance and review of health records, routine and emergency health policies, provision of health education to parents and staff, safety of the program site and transportation policies and procedures.

The second part of the HSCC consists of four self-administered forms used to validate data collected elsewhere in the HSCC and to provide information useful to the training and technical assistance functions of the Project.

a. A Staffing Form. Describes the staff at the program in terms of position, title, length of employment, full versus part-time status, paid versus volunteer status, number of hours involved in direct caregiving and the age range of children served by each staff member.

b. A Health Cost Coverage Form. Records the eligibility of families served by the program for Medical Assistance and/or their enrollment in other prepaid health plans.

c. A Budget Form. Records the funds budgeted for various components of the health care program, e.g., medical personnel and consultants per child, food per diem per child.

d. A Background of Children Form. Records socioeconomic information about the children served by the program in terms of the education, income and occupation of the chief wage earner in each family served by the program.

The third part of the HSCC is called the Physical Plant Tour. Throughout the interview, respondants are asked questions about physical aspects of the day care facility which can be verified by inspection (e.g., Does the site have handwashing facilities adjacent to child care areas?). The physical plant tour form essentially assembles all those items from the questionnaire portion which can be verified by a tour of the program site. The physical plant tour serves to document interview data (e.g., Is room temperature between 65° and 75°) and further, to alert the program staff to all aspects of the program which are being examined.

The fourth and final portion of the instrument includes an audit of ten randomly-selected children's medical records maintained on file by the day care site. The records are examined for the presence of pre-specified health data: e.g., type of health cost coverage, specific screening tests, dates when next medical and dental assessments are due and immunization data. These data are used to determine the extent to which the program has evidence that required routine preventive health services have been received by the children. (For each record, the child's birth date and enrollment date are also noted, but not scored.)

2. Scoring of the Health Standards Compliance Checklist

Scoring of pre-coded items was straightforward. Coding of the open-ended items was not done by the interviewers, but by one individual who used a scoring manual which provides specific guidelines for the coding of each item. This procedure for coding was designed to minimize subjectivity in determining the adequacy of provisions and procedures used by the program. Similarly, the medical record content score was derived from the application of adequacy criteria to data collected at the day care site. Adequacy of medical record content was based on a tabulation of the number of age-appropriate services which were recorded in the child's medical record compared with those which should have been obtained for the child.[1] Records for children enrolled at the site for less than three

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[1]The standards used were the standards for well child care proposed by the American Academy of Pediatrics and are consistent with the requirements of the Early and Periodic Screening Diagnosis and Treatment Program (EPSDT).

months were excluded from this scoring procedure. After a score was derived for each medical record, a mean score was calculated for all the records evaluated from the site. This mean score was considered the site's Medical Record Content Score.

Scoring of the HSCC was constructed to provide quantification of health component compliance in two ways. The first is an item-by-item treatment for all programs. This method was intended to be used for cross tabular examination of items on a pre-training and post-training evaluation across all participating sites. The second method of scoring was to identify clusters of items which dealt with similar aspects of the health component to yield a series of health standards compliance scales. The scoring procedure included the development of sub-scales within several scale areas. Both the individual items and the scores derived from assessing each program's compliance within the scale areas can be used to evaluate the strengths and weaknesses of programs, to evaluate program change, and to examine the relationship of the program's compliance in each scale area with other aspects of the program (e.g., Advocate's knowledge, health attitudes and behavior with regard to health advocacy).

Scale scores were derived by dividing the health standards examined by the HSCC into 16 different content areas. In addition, 16 subscale score areas were derived from subsets of the data collected by the HSCC. Each scale score ranges between 0 and 100. This is accomplished by dividing the actual score the program receives on any scale by the maximum possible score and multiplying the resulting ratio by 100. The scales and subscales of the HSCC are listed in Table 5.

Several scale scores contained items which cannot be scored. The first type of unscored item is one which is non-applicable to a program (e.g., having information on the use of fluoride supplements applies only to programs which are not serviced by fluoridated city water). To account for these items in scoring, the maximum possible score is decreased by the value of the non-applicable items. As a result, all scale scores represent the percent of compliance with applicable standards. In addition to the non-applicable items, there are screening items which indicate for the interviewer that subsequent items should be skipped. The screening item itself is not scored. Items which are skipped because of the screening item and are appropriate to the program are not deducted from the maximum possible scale score since these items deal with necessary components of the program's health standard compliance. There are also verification items which are used to confirm the response with another item. These items are used to assess whether the program should be given credit for another item. They are not scored directly themselves, but determine the scoring of the other items. Items on the HSCC which require verification from objective observations are scored so that the program is credited for compliance only if the objective observation verifies the interview response.

TABLE 5
HSCC SCALES AND SUBSCALES

1. EXTERNAL PLANNING SCALE SCORE (Items 26 to 32)

   This score represents the routine use of appropriate outside sources of expertise to assist in evaluating the entire health component and proposing strategies for solving health related problems.

2. SPECIAL NEEDS SCALE SCORE (Items 33 to 56)

   This score represents an assessment of the extent to which children who are identified by the program as having special needs are reported to have a professional diagnosis and management plan which has been used to plan the child's day care activities. Totally different programming is often not necessary (e.g., visual impairment: glasses must be worn during waking hours).

3. Number of Types of Special Needs Subscale Score (Items 33 to 56)

   This score represents the total number of different types of special needs named by the program as being present among the current population of children.

4. Number of Instances of Special Needs Subscale Score (Items 33 to 56)

   This score represents the number of special needs present without regard to the number of children who may have multiple problems.

5. Number of Children With Special Needs Subscale Score (Items 33 to 56)

   This score represents the number of children with special needs without regard to the number of problems which may affect each of these children.

6. INTERNAL PLANNING & ADMINISTRATION SCALE SCORE (Items 57 to 65)

   This score represents the use of appropriate management techniques by the program in relation to the health component. It includes identification of a single individual who is responsible for implementation of decisions or plans; involvement in scheduling health services; communication between parents and program about needed preventive health services and the outcome of services received.

7. Advocate is Authority Subscale Score (Item 60)

   This score checks if the person named as being directly responsible for the whole health component is the person trained as Health Advocate.

8. Advocate is Listed Subscale Score (Item 58)

   This score checks if the Advocate is listed as being responsible for the direction and implementation of the program's health component, even if not directly responsible for it.

9. Program Provides Screening Subscale Score (Item 66)

   This score identifies programs which provide or arrange for screening tests.

10. HEALTH SERVICES SCREENING SCALE SCORE (Items 66 to 71, 74, 76)

    This score is derived from identification of screening tests performed by the program which are appropriate for the age of children served. The program receives credit whether the program directly provides the screening or assures that the screenings are provided through parental arrangements for the children. This score includes a verification of adequate agency referral and cooperative arrangements to provide the services named by the program.

11. Health Service Screening Consent Subscale Score (Items 66 to 71, 74, 76)

    This score represents the proportion of screening tests provided by the program for which appropriate consent forms are provided to the interviewer.

12. Percent of Appropriate Screening Tests Program Provides Subscale Score (Items 66 to 71 74, 76)

    This score represents the percent of screening tests provided to the children that are directly arranged for by the program as opposed to those which the parents provide.

13. Program Provides Medical Evaluation and Treatment Subscale Score (Item 67)

This score identifies programs which provide or arrange for preventive and diagnostic evaluation and treatment services.

14. MEDICAL EVALUATION AND TREATMENT SCALE SCORE (Items 72 to 81)

This score represents the number of preventive, diagnostic and treatment services (including immunizations, medical, dental and emergency care) appropriately provided for the children by their parents or by the day care program. This score includes a verification of adequate agency referral and cooperative arrangements to provide the services named by the program.

15. Medical Evaluation and Treatment Consent Subscale Score (Items 72 to 81)

This score represents the proportion of services provided by the program for which adequate consent forms are given to the interviewer.

16. Escort Subscale Score (Items 77 to 79)

This score identifies whether escort and/or transportation is provided so that children can receive medical services and keep medical appointments.

17. Percent of Medical Evaluation and Treatment Services Provided by the Program Subscale (Items 72 to 81)

This score distinguishes those services provided or arranged for by the program as opposed to those arranged for by the parents.

18. MEDICAL RECORDS PROCESS SCALE SCORE (Items 82 to 92)

This score is derived from the use of summary and tickler systems, the maintenance of individual health records, the updating of records, the review of records, transferring of records to school, maintenance of confidentiality, use of health information by program staff and communication of program collected health information to health providers.

19. MEDICAL RECORDS CONTENT SCALE SCORE (Medical Record Check Recording Form)

This score represents the result of an actual random sampling of the program's records to determine the content of information recorded on them.

20. HEALTH POLICIES AND PROCEDURES SCALE SCORE (Items 93 to 127)

This score includes the availability of written policies covering all aspects of the health component as well as adequate assurance that policies are used during staff orientation, reviewed annaully, used in self-evaluation and reviewed by staff, parents, volunteers and consultants.

21. HEALTH EDUCATION SCALE SCORE (Items 128 to 143)

This score is derived from an assessment of the frequency and content of health instruction conducted with children, parents, volunteers and staff including discussion of health procedures in the child care setting, use of public service groups and community resource health professionals.

22. STAFF HEALTH SCALE SCORE (Items 144 to 147, 150 to 160)

This score includes assurance that adequate tuberculin screening is performed, the health department has certified all food handlers, pre-employment and continual staff health assessments are obtained, verification that staff members are free of a history of child abuse, adequate sick leave policies exist and staff health habit appraisals are performed.

23. DENTAL CARE SCALE SCORE (Items 161 to 165)

This score includes appropriate use of fluoride supplements, practice of daily hygiene and involvement of local dental health specialists in education for staff, parents and children.

24. EVACUATION, EMERGENCY AND DISASTER PLAN SCALE SCORE (Items 166 to 173)

This score includes adequacy of plans for emergencies, evacuation procedures, maintenance of drill logs, examination and adequacy of posted emergency exit instructions.

25. FIRST AID SCALE SCORE (Items 148 to 149, 174 to 178)

This score includes an assessment of the availability of first aid equipment (verified by interviewer inspection) and of the adequacy and availability of adults trained in first aid procedures.

26. Percent Trained in First Aid of Those Required Subscale Score (Items 148, 149)

This score represents the number of people who should be trained in first aid. It is calculated by using the staff/child ratio for each age group to assure that at least one person per child care group is trained in first aid.

27. First Aid Equipment Subscale Score (Items 174 to 178)

This score represents the percent of compliance on those items dealing with first aid equipment.

28. ENVIRONMENTAL QUALITY AND SAFETY SCALE SCORE (Items 179 to 232, 268 to 270, Plant Tour)

This score represents the environmental quality and safety of the facility with regard to significant hazards, pest control, sanitation, ventilation, temperature, illumination, space, cleanliness, facility cleaning plan, environmental quality and safety surveillance routines, accidental injury logs and approval following health department inspection of the food service aspects of the program.

29. NUTRITION SCALE SCORE (Items 233 to 259, Plant Tour)

This score includes involvement of parents in menu planning to coordinate with home meal patterns, use of written menus, gathering information on feeding schedules, vitamin or mineral supplements, home feeding practices, food preferences, food sensitivities or allergies, availability of adequate supplies of food and formula, feeding practices in the program (e.g., holding young infants for feeding and adequate group feeding routines), types of snacks served and staff involvement in eating routines.

30. Menu Subscale Score (Items 235 to 237, 252, 255)

This score represents compliance with standards of adequate menu development and use.

31. Transportation Subscale Score (Item 260)

This score identifies programs where routine transportation is provided.

32. TRANSPORTATION SCALE SCORE (Items 260 to 267)

This score includes the provision of adequate safety devices in vehicles, driver training, vehicle and accident insurance and attendants with children while in transport.

3. Delete Variables

For 21 of the 32 HSCC scales or subscales described previously, each program can be assigned a score. For 10 indices, referred to as delete variables, no score can be assigned under certain conditions:

a. Four indices concern children with special needs; they are applicable only if such children exist in a program.

b. The screening test scale is not scored for the program if no screening tests are provided or arranged for by the program. If no screening tests are provided or arranged, the screening scale score is assigned a value of 0 based on the rationale that all programs should provide or arrange for screening either directly or by instructing parents to obtain age-appropriate screening tests.

c. A similar approach was used with medical evaluation and treatment services. If no such services are provided or arranged for, then the corresponding indices are not scored for the program and the Medical Evaluation and Treatment Scale Score is assigned a value of 0. The rationale is the same as that given under b.

d. The Routine Transportation Scale Score is deleted for a program if no routine transportation is provided.

Development of the computer program to score the HSCC was based on an item-by-item specification of the score to be assigned in determining credit or non-credit for the item. The detailed scoring manual, computer programs and instruments have been described in previous progress reports and are available from the Principal Investigator.

C. ROLE FORM

1. Instrument Design

The Role Form consists of a list of 68 specific health related activities in which the Health Advocate might be involved at a day care program. These activities are listed in Table 6. The list was generated from an outline devised by the Principal Investigator and Research Associate of the tasks which are required to achieve health component compliance. For example, there are several nutrition related activities listed: evaluating the nutritional program provided for the children, planning daily menus, assuring that appropriate feeding and mealtime practices are followed, preparing food for the children. The Role Form was administered separately by the interviewer to the program supervisor and the Advocate. Thus, two forms of the Role Form exist: the Supervisor Role Form and the Advocate Role Form, each worded accordingly. In both Forms, the status of the Advocate with regard to the activities is examined. Changes in language to clarify each question for the supervisor and Advocate respectively were made.

TABLE 6
HEALTH ACTIVITIES LISTED ON THE ROLE FORMS

1. Contacting appropriate people when an individual in your program has health needs.

2. Contacting appropriate people when groups of individuals in your program have health needs.

3. Maintaining an information file for the program on local health resources for services.

4. Maintaining for the program educational materials concerning various aspects of health (e.g. films, pamphlets, posters)

5. Maintaining the supply of health forms used by your program.

6. Establishing individual health records for children in the program.

7. Updating individual health records of the children: adding information about health services, illnesses, and immunizations which occur after the health record is established.

8. Transferring children's health records to the child's new school when he leaves the program.

9. Reviewing health needs of all children by some systematic method.

10. Performing daily health inspections on the children: checking for signs and symptoms of illness (for example, rashes and fevers, decreased eating, fatigue, etc.) when the child arrives at the program.

11. Arranging for referral and consultation about problems identified by the daily health inspection.

12. Following a medically approved schedule of health supervision-services for children: a schedule of checkups, screening, laboratory tests and immunizations which health authorities say children in the program should be receiving at certain ages.

13. Arranging for health supervision services for the children, such as the checkups and tests mentioned in Activity 12.

14. Giving the children checkups, including an undressed physical exam.

15. Assuring that children keep medical and dental apppointments and noting when such appointments are missed.

16. Reviewing the health data gathered on the children with other members of the staff who are involved with the children.

17. Having caregivers' written concerns about a child's health sent to the health provider, when the child goes for his checkup.

18. Determining whether children are eligible for medical assistance or some other form of health insurance benefits.

19. Budgeting funds for dental, nutritional, medical, or mental health aspects of your program.

20. Participating in planning for the management of any children with disabilities or special health problems in your program.

21. Helping to gather specimens for urine and blood testing.

22.-27. Providing or arranging for screening tests for the children: e.g.

vision, hearing
height, weight and/or head circumference
developmental screening or assessing school performance
dental screening
TB skin testing

28. Providing safety screening of the children's home environments by checking with parents about likely hazards.

29. Providing or arranging for immunizations for the children.

30. Administering medicine to children in the program; including measuring, labelling and storing medicine.

31. rifying that someone administers prescribed medication for the children at home.

32. Checking the safety and comfort of the child care environment.

33. Evaluating the nutritional program provided for the children.

34. Planning daily menus.

35. Assuring that the appropriate feeding and meal time practices are followed.

36. Preparing food for the children.

37. Having children practice dental hygiene.

38. Obtaining toothbrushes for the children.

39. Assuring that children obtain fluoride treatments or supplements.

40. Using mental health consultants in the program for staff training or workshops.

41. Providing preventive mental health services for all of the children.

42. Referring appropriate individual problems to mental health specialists for observation, testing, and/or treatment.

43. Gathering information about a child's symptoms when he is ill.

44. Managing minor illnesses in the child care program.

45. Discussing health matters with parents.

46. Discussing health matters with other staff members.

47. Discussing health matters with volunteers and students involved with the program.

48. Drafting and reviewing written health policies for the program.

49. Checking to see that health policies of the program are followed.

50. Assuring participation of staff, parents and consultants in the review of the program's health policies.

51. Initiating or planning evacuation and fire drills.

52. Logging evacuation drills.

53. Drafting evacuation plans.

54. Posting evacuation plans.

55. Informing others about evacuation plans.

56. Administering first aid.

57. Gathering and maintaining first aid equipment and supplies.

58. Training others in first aid.

59. Planning for safe transport of children in emergency situations.

60. Transporting children in emergency situations.

61. Assuring that all vehicles used to transport children have met safety inspection standards.

62. Assuring that safety restraints for the children are provided in all vehicles used for transporting children.

63. Assuring that all children use safety restraints when transported by the program.

64. Riding with children when they are transported by the program.

65. Providing health education for the staff.

66. Checking to see that health supplies and equipment, e.g. thermometers, are maintained.

67. Assuring that all staff members have on file with the program a physician's statement indicating that they are physically and emotionally healthy.

68. Assuring that all people who handle food have a food handler's certificate.

Five questions were asked of both the supervisor and Advocate with regard to each activity. The first question examines whether the Advocate is at all involved in the activity. If the Advocate is not involved in the activity, the second question examines the reason for non-involvement. Alternative responses to the second question include the activities not being appropriate to the children served, the activities being blocked administratively, the activities not being planned for by the program, the activities being handled by a staff member other than the Advocate, or some other reason specified by the respondant. If the Advocate is involved in the activity, the respondant is asked about the nature of his/her involvement, either by advocating for performance of the activity only, performing the activity only, or a combination of advocacy and performance roles. If the Advocate combines the advocacy and performance roles, the respondant is asked whether more time is spent in advocating or in performing the activity. Lastly, if the Advocate is involved in the activity, the respondant is asked whether the Advocate, the supervisor, or the Advocate and supervisor together decide that the activity should be performed.

Two additional questions are asked on the Advocate's Role Form. For each activity, regardless of the Advocate's involvement or non-involvement, s/he is asked whether s/he had ever been taught or told that the activity is an aspect of the health component of day care. If s/he was informed, s/he is asked for the source of this information: HAT Training, other formal training, on-the-job training, life experience or some other source which s/he specifies. The other question on the Advocate Role Form deals with the proportion of time which the Advocate assesses as spending on the performance of non-health related activities at the day care site and the nature of different types of tasks which are performed.

2. Scoring the Role Form

A series of scores was derived from both the Supervisor and Advocate Role Forms. The most global measure was the number of activities in which the Advocate is involved compared with the total number of activities appropriate to the program. Measures of cause for non-performance determined as administratively blocked, failure to plan and so forth were similarly derived. The freedom of the Adovcate to initiate activities was also scored on the basis of responses to "who decides...". From the two questions concerning advocacy versus performance, advocacy and performance scores were derived by measuring the percent of activities in which there was involvement, in which there was performance and in which there was a combination of both advocacy and performance. Additional scores were derived from the Advocate Role Form concerning the level of Advocate knowledge, i.e., the percent of all items in which s/he knows to be a part of the health component of the day care program and the source of this knowledge (HAT training versus some other information source).

Non-applicable items on the Role Form were handled in the same way as those on the HSCC. There are only eight potentially non-applicable items on the Form. Whether any of these items is non-applicable to a specific program can be determined directly from the responses to the HSCC. These items have to do with the management of children with special needs, involvement in gathering specimens for laboratory tests, administration of medication, involvement in provision of fluoride supplements, discussing health matters with volunteers and students, assuring that vehicles meet safety standards, assuring that children use safety restraints when being transported and assurance that adult supervision is provided during transportation.

Each of the scales resulting from scoring of the Role Form are detailed in Table 7. As with the HSCC, detailed scoring procedures and instruments have been previously submitted and are available from the Principal Investigator.

TABLE 7

SUMMARY ROLE FORM SCORES

SCORE ABBREVIATION	ITEM DESCRIPTION	ADVOCATE FORM	SUPERVISOR FORM
APP	Number of activities appropriate to program, used as baseline.	X	X
INV	Proportion of appropriate activities in which advocate is not involved.	X	X
NON	Number of appropriate activities in which Advocate is involved.	X	X
PIN	Proportion of activities in which Advocate is not involved which are perceived as inappropriate to the program.	X	X
ADB	Analogous to PIN for activities which are administratively blocked.	X	X
LPL	Analogous to PIN for activities not planned for.	X	X
ELS	Analogous to PIN for activities for which someone else is responsible.	X	X
PER	Proportion of activities in which Advocate is involved which s/he performs but does not advocate.	X	X
ADV	Analogous to PER for activities advocated but not at all performed.	X	X
MIX	Analogous to PER for activities partially advocated and partially performed by Advocate.	X	X
MIS	Proportion of activities in which dvocate mis-perceives his advocacy versus performance role.	X	-
TPER	Proportion of activities in which Advocate is involved which he either solely performs or predominantly performs.	X	X
TADV	Analogous to TPER for advocacy	X	X
INAD	Proportion of activities in which dvocate is involved which are initiated by the dvocate.	X	X
INSU	Analogous to INAD for supervisor initiation.	X	X
INMX	Analogous to INAD for mutual supervisor and Advocate initiation.	X	X
INF	Proportion of activities on whole form for which Advocate is aware that the activity is an aspect of the health component.	X	-
HAT	Proportion of activities Advocate is aware of as per INF, which he learned about through HAT.	X	-
FOR	Analogous to HAT for learning through formal training.	X	-
JOB	Analogous to HAT for learning on-the-job.	X	-
LIF	Analogous to HAT for learning through life experience	X	-
NOT	Time spent by Advocate in non-health activities.	X	X

D. HEALTH KNOWLEDGE TEST

1. Instrument Design

The Health Knowledge Test consists of 74 five-alternative multiple choice items and six items requiring that parts of the body (e.g., middle) be named. The items, 80 in all, are tied to the specific content of the sessions. Item Clusters do not correspond exactly to individual topics or sessions because of the integrated structure of the course. Several topics were introduced in one session and covered in greater detail in a later session.

The content areas covered by the Health Knowledge Test items are summarized in Table 8. The table shows that the content of Session 12 was not addressed by the Test. The morning of Session was used for the immediate post-training administration of the test. The afternoon portion of Session 12 was devoted to planning activities in which the supervisors and local health consultants joined the trainees.

2. Scoring the Health Knowledge Test

Scoring the Health Knowledge Test was designed to provide scores for each of the ten item clusters of subject content.

E. HEALTH OPINION SURVEY

1. Instrument Design

The Health Opinion Survey was developed to tap attitudes about health held by program supervisors and Health Advocate trainees. The items of this instrument were developed from a list of attitudes deemed by the Principal Investigator to be the attitudes which a successful Health Advocate should hold concerning health in child care. The ten attitudes are:

(1) Health is an area which can be grasped by people who are not health professionals.

(2) Health providers will respond with health services when appropriate. negotiations and arrangements are employed.

(3) The view of the health provider as possessing a mystic is inappropriate. The health provider should be viewed as an individual who has obtained health knowledge and skills which s/he offers to clients for reimbursement subject to the pressures of the marketplace.

(4) Multiple sources of information are usually available for a given area of health concern. It is reasonable to seek out satisfactory answers to health questions from other sources when the first source consulted has not provided an understandable explanation.

(5) It is reasonable to obtain personal information about health from an individual only if having the information will permit a beneficial effort to be made on behalf of that individual.

(6) It is useful to have a set of commonly successful strategies to obtain services from the fragmented systems of health care.

TABLE 8
CONTENT OF THE HEALTH KNOWLEDGE TEST

SESSION NUMBER	ITEM CLUSTER	ITEM CONTENT
1 & 2	No. 1	Ideal Advocate Action, goal of advocacy, knowledge required by Advocate, action steps to perform as an Advocate, keeping up on new health services, keeping track of health services and material sources, necessary information to file health reference material, health records.
3	No. 2	Daily health inspection procedure, daily health inspection purpose, source of immunization information, normal ear wax, mumps, impetigo, tonsils and adenoids, content of the health record.
4	No. 3	The least urgent screening test, reason for health screening, Advocate's role and screening test, Denver Developmental Screening Test, Sickle Cell Anemia, diseases prevented by shots or drops, aspirin dose for children with high fever, procedure for administering medication.
5	No. 4	Most common poison taken by children, symptoms of lead poisoning, lead poisoning, health hazards causing brain damage, label parts of the ear, nose, throat, tissue name and function.
6	No. 5	Ideal temperature for child's room, hazards of bottle propping, leading cause of death in children under 15, appropriate number of toilets and basins for children, source of vision screening materials, meaning of Snellen Test results, referral recommendations, Snellen Eye Test procedure, facts about the eyes.
7	No. 6	Milk needs after 1 year of age, four basic food groups, implication of baby fat, age to initiate routine dental care, personal dental hygiene, fluoride facts, mental health services, sexual behavior in children.
8	No. 7	Common early symptoms of childhood illness, constipation, the meaning of a child repeatedly pulling his ear, treatment of the vomiting child, reading the Tick Sheet, what is Medicaid, source of free health care.
9	No. 8	Integration of children with disabilities into the day care program, procedure for integration of special needs children, classroom for children with special needs, grouping children with special needs, evaluating a child's progress, visually impaired children, talking to deaf children, teaching mentally retarded children.
10	No. 9	Health policies, safety evaluation of child care facility, methods to stop bleeding, procedure if child is not breathing, procedure if child chokes on food, procedure for a serious accident sustained by a child, procedure for a child poisoned by an overdose of aspirin, procedure for safe transportation of children in cars.
11	No. 10	Advocates view of health education, health education procedure for a young child, handling child's questions, effects of gonorrhea, child bathing, ear cleaning, effects of baby standing before walking, outcomes of smoking.

(7) Planning and organization for health are valuable and do not simply generate red tape.

(8) It is appropriate to bring a health problem to representatives of different disciplines if their skills are appropriate to the problem's solution.

(9) It is appropriate to foster independence and self-sufficiency rather than encourage dependency.

(10) The Advocate should disseminate health information to others.

To construct the Health Opinion Survey three items were written which would tap each of the 10 attitudes listed above. A four point response scale (strongly agree, agree, disagree, and strongly disagree) is allowed for each item. The three items used to tap each of the 10 attitudes are listed in Table 9.

2. Scoring the Health Opinion Survey

For each item in the attitude scale there is a desirable pole from the point of view of appropriate attitudes which would be held by a successful Advocate. Thus, a respondant's answers may be scored to assess his deviation from the ideal profile for each item. The sum of these deviation scores across the 30 items produces an overall deviation score for each subject. These scores may be confusing: it should be remembered that this is the only instrument in this Project for which a higher score indicates a lesser degree of concordance with desired outcomes.

TABLE 9
HEALTH OPINION SURVEY ATTITUDES

ATTITUDE NUMBER	ITEM	
1	1	Doctors and nurses are the only ones who know a significant amount about health.
	2	Most people know as much about their own health as a doctor can find out in an examination.
	3	People who aren't trained professionals should not give advice on health.
2	4.	Doctors, nurses or other health care providers are usually too busy to give advice, unless you are paying for a visit.
	5.	If a doctor, nurse, or other health care provider is not very interested in your problem, there is little you can do to get his services.
	6.	Unless you know doctors or other health care providers personally, it is very difficult to get their services.
3	7.	Professional health care providers are much like other people, except for their medical training.
	8.	Professional health care providers are too busy to be interested in problems of individuals.
	9.	Those who have professional medical training may tend to be somewhat more aloof than other people.
4	10.	There are some people who will never learn good health habits, no matter how hard you try to teach them.
	11.	If a person has success rather than failure at one task, he is more likely to succeed on a harder task.
	12.	There are almost always different ways to get a good result.
5	13.	If a person is not enthusastic about improving his own health, he should be left alone.
	14.	It is alright to ask for very personal information about a person's health if you are trying to help him improve it.
	15.	No one but a parent should know a child's personal health history.
6	16.	In order to help people, it is sometimes necessary to arrange things without their knowledge.
	17.	It's alright to offer a doctor a favor, such as a source of patients in return for his helping you.
	18.	It is always best to approach health care providers and those in authority directly to get them to help you.
7	19.	The most important part of any program is organizing and planning it.
	20.	One should not waste time by holding meetings to "organize" and "plan" health-related activities.
	21.	The more "organized" a program, the more useless red tape you have to cut through.
8	22.	The best way to handle health problems is to have an expert for each specific kind of problem.
	23.	Better results are likely if a child's health problems are discussed with a number of people, even those who are not specifically experts in the problem area.
	24.	The non-professional in the health field must be careful to discuss problems only with experts in the appropriate area (e.g., a speech therapist) and not with non-experts (e.g., child's teacher).
9	25.	Workers in day care programs should do as much as they can for a child before they involve the child's family.
	26.	If some children and their families need more attention than others, there is little the worker in the day care program can do about it.
	27.	It is best to let people do as much as they can for themselves.
10	28.	Information about certain subjects such as first aid should be given to only those who will be likely to need it.
	29.	It is the obligation of the health worker who knows about a problem to talk about it and try to solve it.
	30.	It is the obligation of the health worker to teach others what he has learned about health.

SECTION IV – DATA COLLECTED WITH THE USE OF INSTRUMENTS DEVELOPED BY THE PROJECT

SECTION IV

DATA COLLECTED WITH THE USE OF INSTRUMENTS DEVELOPED BY THE PROJECT

A. OVERVIEW

1. Organization of the Presentation of Data

The presentation of data is organized into five parts. The first is an overview of the presentation plans and the use of the data. This section deals with problems (issues) associated with data use, i.e., data of Advocates and supervisors who had more than one site enrolled in HAT training, changes in the Advocate and/or supervisor at a site during the course of participation in HAT, and the handling of missing data.

In the second part, pre-test data are presented. In the original proposal, it was suggested that there might be a spread of effect as increasing numbers of day care programs entered into HAT training. It was expected that programs which entered HAT training early might share this experience with programs which had not yet entered training in such a way that the latter programs might improve their health components prior to entering HAT training. Alternatively, influences outside of HAT might bring about observed changes in compliance unrelated to any activity undertaken by the Project, e.g., the implementation of the Early and Periodic Screening Diagnosis and Treatment Program (impact of the Zeit Geist). Operationally, this spread of effect or outside influence would be expected to manifest intself in higher pre-test scores of later over earlier trained sites. To test these hypotheses, the pre-test scores of Cycles A, B, C, D and G were contrasted in a series of analyses of variance.

The third part considers changes observed from pre to post-testing individually for each instrument. In this section, tests of significance on the scale scores of all tests are considered.

The fourth part considers the process by which observed changes in the HSCC occurred. Changes on the HSCC are predicted from changes in Advocate Opinion, Knowledge and Role.

The fifth part compares pre and post HSCC data for sites in Cycles A, B, and C which received training in the interval between pre and post assessment with similar interval data from sites in Cycle E/F before they received any training - to examine for the effects of evaluation.

The sixth part discusses some comparisons and analyses which might yield interesting and useful information, but which were not performed within the demonstration period.

For the convenience of the reader, all the tables for Section IV have been grouped at the end of the narrative for this Section.

2. Sample Sizes and the Use of Data

The HSCC was administered as a pre-test to 142 individual center and family day care sites. There was one site which was pre-tested, then dropped out of HAT and entered at a later cycle. Only second administration data are considered for this site. Nine of the 153 sites which participated in the Project were enrolled in the Pilot Cycle when the final version of the HSCC was being developed. Consequently, their pre-test HSCC data cannot be used in the pre-test data presentation or in the pre-post change analysis. One-hundred twenty-five sites received the HSCC post-test. Of the post-tested sites, one was a new site which had not existed at the pre-test. The Advocate at this new site had been the Advocate at another pre-test site which had closed in the interim between pre and post-testing. For a second site, both pre and post-tested, the Advocate did not complete training. With the elimination of these two special sites, there were 123 sites pre and post-tested on the HSCC, for which the one-year pre-post assessment sequence was completed.

When pre-test data were analyzed for the HSCC and for all other tests, all available pre-test scores were treated in analysis, even if the programs later failed to complete the post-assessment. This was done to provide a picture of the status of the health component in a large metropolitan area. If only the pre-test data of those sites which ultimately completed the post-assessment were examined, the picture of the status of health in day care would have been biased through the selection of sites which were sufficiently concerned and enthusiastic about their health components to remain in the program or were able to stay open until the one-year post evaluation.

Data were handled in the same way in deriving post-test summary statistics. All post-test data available were entered into summary statistics.

a. Advocates and Supervisors with Multiple Sites

Some Advocates, and to a large extent supervisors, represented more than one program site when they entered into HAT training. In all, 12 Advocates had more than one site on both the pre-test and post-test administration. As part of this complement of multiple sites were three sets of family day care homes, each set of homes handled by one Advocate. For supervisors, 16 had more than one site on pre-test administration, while 14 had more than one site on post-test administration. In some instances, trainees representing the multiple sites were spread across training cycles, i.e., a supervisor might have an Advocate for one site trained in one cycle with an Advocate for a second site trained in a second cycle. More frequently, the multiple sites of one person were represented in the same cycle. Where multiple sites occurred in the same cycle, the Advocate and supervisor were given all tests except the HSCC only once.[1] The one set of scores from an Advocate or supervisor was used in analysis. The only exception to this was in the case of several Supervisor Role Forms. In these cases, supervisors felt that the Advocates at the various sites s/he supervised had different roles, and responded differentially on the Role Form for each of his several sites. In these infrequent instances, the data of each administration of the Role Form to the supervisor were treated separately in analysis. The Role Form posed a particular problem in instances in which one protocol applied to several sites. There are eight activities on the Role Form which may or may not be applicable to a site, depending on the health component at that site. For example, if a site has no special needs children, the Role Form activity dealing

[1] The HSCC was administered separately for each participating site.

with the Advocate's involvement with special needs children is not applicable to that site. Activities not applicable to a site are eliminated from scoring. In the case of an Advocate or supervisor with multiple sites, the appropriateness of these eight items was dealt with according to the following rule: if an activity was applicable at at least one of the sites of a multiple set, then the activity was deemed applicable for that Advocate and was entered into scoring.

The fact of multiple sites in different cycles posed another problem--that of multiple pre and post administrations of the Health Opinion Survey. Where this occurred, in the case of Supervisor Health Opinion Surveys, only the first administration of the pre-test and post-test were used in analysis. So, for example, if a supervisor took the Health Opinion Survey in association with a trainee in Cycle B and then again in association with a trainee in Cycle C, only the Cycle B data of both pre and post administrations were employed in analysis.

b. Changes in Personnel During Site Participation and Pre-Post Analysis

Of the 123 sites which participated in the full one-year pre-post assessment, there were changes in the Advocates of 18 sites and in the supervisors of 24 sites.[2] These personnel changes sometimes overlapped within sites, i.e., both the supervisor and Advocate changed in the course of the year. There were in all, 33 sites with Advocate and/or supervisor changes.

In the pre-post comparison of the HSCC scale scores, all 123 sites which completed pre and post HSCC were entered into analysis. This was done, as the analysis was designed to test the impact of the HAT training on the health component of a site, whether individual participants in HAT remained at the site.

A different approach was taken with pre-post analysis of the Role Form, Opinion Survey and Health Knowledge Test. Pre-post analysis of these data were directed toward assessing the impact of training on the participants in that training. For this reason, only the data of those supervisors and Advocates who completed the entire sequence of assessment and training activities were employed in pre-post analysis of tests other than the HSCC.

In the final section of the data analysis, an attempt was made to account for changes measured on the HSCC from changes measured on the other instruments. For these analyses the data of all sites which participated for the year were employed (see below for exceptions occasioned by missing data), whether or not the supervisor and Advocate had completed the activity sequence or had been replaced during the course of the year. Hence, in some cases, the pre-test scores of an Advocate at a site were compared with post-test scores on a new (but untrained) Advocate at that site in accounting for HSCC changes. The rationale for this use of data was that a change in opinion, knowledge and/or role behaviors might be relevant to a change in the health component of a site whether the change was occasioned by the change within a single Advocate or by a change from one Advocate to another. There were three exceptional cases in this regard. In two instances, there were two sites which had different Advocates on the pre-test, but one of these two Advocates was handling both sites by the time of the post-test.

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[2] As illustrated in Figure 5 on page 15 of this report, out of 131 Advocates enrolled, (Cycles Pilot to E/F) 30 Advocates were lost from training or from their sites by the time of the post assessment. These Advocates represented the original 153 sites. The Advocates from the 123 sites discussed above are those who represent sites for which paired pre-post HSCC data are available.

In these cases only the site of each pair for which one Advocate remained for the full year were employed in the analysis of accounting for change in the HSCC by change measured on other tests. The reason for this was that there was only one post-test data set on the Health Opinion Survey, Health Knowledge Test and Role Form to apply to two sites. Keeping the two sites of each pair in the analysis would have required duplicating post-test scores on all but the HSCC for the second site. This is not legitimate from the point of view of employing independent cases in analysis. The third case was the reverse of the first two, i.e., two sites had the same Advocate at the pre-test, but a new Advocate took over one of the sites on the post-test. In this case again, retaining both sites as individual cases on the pre-test would have required duplication of the one set of pre-test scores for use with the two sites. In this instance again, only the data from the site which had the same Advocate on the pre and post-test were employed in the prediction of change.

c. Handling of Missing Data

As stated above, in separate pre-data summaries and post-data summaries, all available data were employed to derive summary statistics. Hence, even if the scores of an Advocate were missing on one test, the rest of his data from other tests were employed.

In pre-post analysis of individual instruments, it was necessary to eliminate from the analysis of each instrument cases in which either the pre-test or the post-test measures on that particular instrument were missing. In the prediction of change on the HSCC, the total scores from the Opinion Survey and Knowledge Test plus seven scores from the Role Form were used as predictors. In the few instances in which either a pre or post-test Opinion or Knowledge Test was missing, the case was retained. The option of pairwise deletion of missing data was employed. However, if either a pre or post-test Role Form were missing, the case was eliminated, since the large majority of predictors for the analysis were taken from the Role Form.

B. PRE-TEST DATA

1. Description of Trainees

A description of trainees who participated in training was given in Section II of this report. Cycle by cycle data provided by the trainees are given in Table 10. The data reported for Cycle E/F are of two types, the data submitted by Advocates who were being retested one year after their first evaluation to assess the pre-test sensitization effects, and the initial application data from new trainees entering training after only one assessment (E/F Nouveau).

By way of review, trainees were almost all females, with 70% between the ages of 21 and 40. Slightly over half were married. Two-thirds of the trainees had children; their youngest children were predominantly of schoolage, with only a fourth of trainees having children five years of age or younger. Three-quarters of the trainees had some education beyond the high school level. Of those who held degrees, these degrees were, in the main, relevant to work in day care, e.g., 26% of the trainees who reported degrees or certification reported child development or education as the area; 25% social work; another 22%, nursing. Almost half the trainees held positions classifiable as social service positions. Almost a quarter had positions of an educational nature with another 20% of the trainees holding administrative positions. About 40% of trainees had salaries in the range of $7,001 to $10,000 per annum, with another third having salaries in the range of $5,000 to $7,000 per annum.

2. Description of Programs

A description of the 142 sites in Cycles A through C which were pre-tested on the HSCC is given in Table 11. Eighty-three percent of the programs were federally funded center day care programs; 89% had been in operation for over one year. Almost 90% of the programs served preschool children (3 to 6 years of age); 10% served children under 18 months of age, 25% served children 19 months to 3 years; 46% served children of schoolage.

There were approximately equal numbers of programs with homogeneous and heterogeneous age grouping. The modal number of hours of operation was ten hours per day, with a median minimum number of hours per day that children were in the program's care of 5.5 hours and median maximum number of hours of care of 9 hours. The median number of child care places at a site was 40; the median number of children registered was 39. Slightly over a third of the programs served only Black children with almost another third serving both Black and White children; 17% served Spanish American, White and Black children. In programs with Spanish American children, most of these children spoke English.

3. Health Standards Compliance Checklist (HSCC)

An item by item summary of pre-test and post-test responses to the HSCC is presented in Table 12. In Table 13, a summary of derived scale scores on the HSCC is presented with data presented separately for each cycle. As can be seen in both, the individual item and the scale score presentation (Tables 12 and 13 respectively), there was wide variation in levels of pre-test compliance across areas of the health component. For example, pre-test compliance with Internal Planning standards was high, while compliance with External Planning, Special Needs and Medical Record Content standards was low.

This variation in compliance across areas of the health component was in contrast with the relative similarity of compliance in particular areas across cycles.

In Table 4, the compliance scores of Cycles A, B, C, D and G are contrasted to examine the previously described spread of effect or outside influence hypotheses. Differences among cycles were tested with one factor analyses of variance applied to each HSCC measure. Where required by the significance of the overall test, post hoc comparisons among pairs of cycle means were performed using the Tukey A (Honestly Significant Difference) procedure. If there were no systematic spread or influence, no ordered significant differences between pairs of cycles of the form Cycle A$<$B, B$<$C, C$<$D, D$<$G would be expected. If significant differences occurred between cycle pairs, with no spread or influence, these differences should occur equally often in both directions, i.e., that of an earlier cycle exceeding a later cycle in compliance and the converse. There are sixteen main scale scores on the HSCC, plus additional derived subscale scores. (The scale versus subscale scores are distinguished in Table 14 by indenting of subscale scores under the scale scores.) There were no differences among cycles on nine of the 16 compliance scales.

Across the seven remaining scales, there were eight cases of pairwise differences among means. Five of these eight differences involved Cycle C which was lower than an earlier case, in contradiction to the spread or influence hypotheses, and lower than a later cycle on two scales. The other three cases

involved Cycle G which was higher than earlier cycles, in support of the spread or influence hypotheses. Overall, five of the eight pairwise differences were in support of the spread or influence hypotheses. Given the 160 possible pairwise comparisons with only five in the predicted direction, ($\frac{n[n-1]}{2}$ or 10 pairwise comparisons on each of 16 scales), there was no evidence favoring the spread or influence hypotheses on the HSCC.

4. Supervisor Role Form

By-cycle summaries of pre-data derived from Supervisor Role Forms are given in Table 15 with contrasts among Cycles A, B, C, D and G given in Table 16. One area of the Role Form, that of the supervisors' reports of the nature of the Advocates' involvement in health related activities lends support to the spread or influence hypotheses. One goal of HAT training was to teach Advocates to advocate the performance of health related activities rather than to perform the activities themselves. Cycles C, D and G reported significantly less direct performance of activity than did Cycle B. In contrast, Cycles D and G reported more involvement through mixtures of performing and advocating than did Cycles A and B. Cycle C reported more involvement through mixtures of performing and advocating than did Cycle B.

Another interesting finding in the pre data is that in all cycles the reason for non-involvement is rarety that the supervisor perceives the task to be inappropriate to the day care setting. This finding suggests that day care workers in the field agree that the tasks listed by HAT are appropriate to the day care setting.

5. Advocate Role Form

Pre-training responses to the Role Form are summarized in Table 17 with contrasts among cycles given in Table 18. In the area of direct performance of activities, a similar decrease to that reported by supervisors was reported by Advocates. Less performing was reported by Cycles C, D and G than by Cycle B, and by Cycle D than C in support of the spread or influence hypotheses, with only the rise of direct performance from Cycle A to B in contradiction with the hypotheses. A mixture of performing and advocating decreased from Cycle A to B but then rose significantly to Cycles C, D and G, again in support of the spread or influence hypotheses. Total performance in Cycle B exceeded than in Cycles A and D, while total advocacy in Cycles A and D exceeded that in Cycle B.[3] Cycle B, also differed from Cycles A, D and G in that the Advocates of Cycle B initiated more activities than in the other cycles.

The Advocates concurred with their supervisors that the tasks listed by HAT were appropriate to the day care setting. On-the-job training is by far the most often named source of knowledge about health on the pre-test, accounting for half to three-fourths of the responses. In contrast, about 10% of the Advocates indicated that their awareness of health activities came from formal training. In view of the fact that so many of the trainees reported some college level study in education, social service or nursing, this finding suggests that day care health awareness is not communicated by these forms of education.

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[3] The five measures of the nature of involvement are somewhat redundant. The Total Performance score is the sum of the Performance score plus the percent of activities which the Advocate both performs and advocates, but which s/he more often performs. The Total Advocacy score is similarly calculated from the Advocacy Score plus the percent of activities which the Advocate both performs and advocates, but which s/he more often advocates.

6. Supervisor Health Opinion Survey

Pre-training Supervisor Health Opinion Surveys are summarized in Table 19. As shown in Table 20, there was only one significant pairwise difference between cycles over all 10 attitudes.

7. Advocate Health Opinion Survey

Health Opinion Surveys of Advocates are summarized in Table 21 with contrasts among cycles given in Table 22. As with Supervisor Opinions, no evidence of spread or influence was noted on Advocate Opinion protocols.

8. Advocate Health Knowledge Tests

Advocate Health Knowledge Tests are summarized in Table 23 with contrasts among cycles given in Table 24. Again, there was no evidence of spread or influence in these data.

9. Summary of Part B

Pre-test data were examined for spread or influence, i.e., for later cycles to show higher pre-test scores by virtue of a "rub-off" from the training of proximal sites in earlier cycles or because of the influence of some factors unrelated to Project activities. The only evidence in support of lay in the nature of the Advocates involvement in health component activities. Advocates decreased the percent of activities they simply performed but did not at all advocate from Cycle B to Cycle G, while the extent to which Advocates mixed performing and advocating increased from Cycle B to Cycle G.

C. PRE-POST CHANGE

In this section, change from pre to post-testing on each instrument is examined. For each instrument post-test data are presented followed by comparisons of corresponding pre and post scores examining significance of change as a function of participation in HAT.

1. Description of Trainees

As shown in Table 25, the description of trainees at post-evaluation essentially mirrors that of trainees at pre-evaluation. The only noticeable difference is that while only 75% of trainees reported some college education on the pre-application, almost 90% reported some college education on the post-test evaluation. There are at least two potential reasons for this change. One possibility is that Advocates who dropped out and/or were replaced during the course of the HAT Project were selectively those with less education. A second possibility is that Advocates who remained in the HAT Project acquired further education during the pre-post period. Time did not permit an examination of these two alternatives for this report.

2. Health Standards Compliance Checklist (HSCC)

Post-test scores on each scale of the HSCC are presented for each cycle in Table 26. For this summary, all available post-test data are presented, whether or not pre-test data were gathered on the site. Hence, post scores from the Pilot sites are included. The sites which were post-tested were described in Table 11. An item-by-item summary of post-test scores was presented in Table 12. For each scale score of the HSCC, a t-test was run to test for changes in compliance after training. The results of these tests are given in Table 27. There was significant gain in compliance on every overall scale score of the HSCC. Areas showing no change were identified through an examination of subscale scores. The preparation of consent forms did not improve. Neither did programs increase the number of screening tests and types of medical evaluation and treatment the programs themselves provided or arranged. While the proportion of programs providing or arranging for any screening tests did not increase significantly, this percent was already high at the pre-test administration. This finding may relate to the community-wide difficulty in obtaining health services from health service providers without direct day care financing. Both day care and health service programs suffered funding cutbacks during the demonstration period. Lastly, the percent of programs providing routine transportation remained at a stable high level from pre to post test. The provision of routine transportation is not a measure of health advocacy, but was used as a marker for the applicability of transportation safety items.

In addition to the health compliance data gathered by the main body of the HSCC, Part D of the HSCC gathers information on staffing patterns, budget for the health component, socio-economic status of program clients and third party payors used by the day care program clientele. Preliminary summaries of these data have been used to interpret compliance data and to identify areas requiring policy development for local agencies. Final analyses of these data were not completed during the demonstration period.

3. Role Form Supervisor

Cycle-by-cycle summaries of the post-test responses to the Supervisor Role Form are given in Table 28. If a supervisor had more than one site and gave the same responses for all sites, his data were entered into the summary once in the cycle which contained the earliest site trained. For example, if one supervisor had a site in Cycle C and another in Cycle D, his responses were summarized with the Cycle C sites. Only if a supervisor with more than one site gave different responses to the Role Form for the various sites were his responses to the various sites entered separately.

The pre-post comparisons of supervisors are given in Table 29. Note that the data of 70 supervisors are entered into this analysis. These represent supervisors who went through the full HAT process. If a supervisor of a particular site was pre-tested but this supervisor left the site and a new supervisor was post-tested, the Role Form Supervisor data for this site was dropped from the pre-post analysis.

There was a substantial gain (from 41% in pre-test to 59% in post-test) in the percent of activities in which supervisors reported that Advocates were involved. Although reported reasons for non-involvement remained stable, supervisors reported a change in the nature of Advocates' involvement. This change was a

decrease in the percentage of activities which they both advocated and performed and a tendency to an increase in the percentage they only advocated. These changes are reflected by the significant decrease in the Total Performance Score and a significant increase in the Total Advocacy Score. (These final two scores are composite scores. The Total Performance Score is the sum of the Perform Only Score plus the percentage of activities Advocates both perform and advocate, but which they perform more than they advocate. The Total Advocacy Score is the sum of the Advocate Only Score plus the percentage of activities they advocate more often than they perform.) The reason for this change toward increased advocacy and decreased performance are not clear. Possibly the change is a result of realistic time constraints. Possibly the Advocates learned to disperse the performance of tasks to spare more of their own time for advocacy.

Finally, there was a tendency for the supervisor to make more decisions that an activity should be performed on the post-test over the pre-test. Perhaps supervisors become sensitized to the need for health tasks to be assigned by the weekly "teach-back" and other communication of training experiences brought back to the site by the Advocate. This increased awareness of health may lead the supervisor to make more decisions about the assignment of health tasks in the program.

4. Role Form Advocate

Advocate Role Form responses are summarized in Table 30. Advocates with multiple sites were handled in the same manner as were supervisors with multiple sites in the preparation of the cycle summaries. Pre-post comparisons on the Advocate Role Form (Table 31) were handled in the same manner as were Supervisor Role Forms; only those Advocates who remained throughout the year were included. Changes in role reported by Advocates in many ways mirrored those reported by supervisors. Advocates concurred with their supervisors in reporting that they were involved in more activities at post over pre evaluation. They reported that they performed fewer activities after training, while more frequently both advocating and performing activities. As had supervisors, Advocates reported an increase in the number of activities for which the supervisor made the decision that they would be performed. Advocates, but not supervisors, reported changes in reasons of non-involvement. On the post-test, lack of planning was given less often as a reason of non-involvement than on the pre-test. In contrast, that someone else was responsible was given as a reason of non-involvement more often after training. Advocates, though not supervisors, reported an increase in the amount of time spent on health advocacy related activities after training. Advocates reported an increase in the number of activities of which they were informed that they were part of the health component. When asked to report where they had learned about the activities which comprised the health component, HAT was the most frequent response given after training.

5. Supervisor Health Opinion Survey

The post-test responses of supervisors to the Health Opinion Survey are given in Table 32. Supervisors with multiple sites had been given this instrument a number of times throughout training. For these supervisors the first administration of the Opinion Survey a year after training was used for post-test response. For change analysis, only the data of supervisors who had remained with a site throughout the one year involvement in HAT for that site were used. Further, where a supervisor had had multiple sites, only his first pre-test and first post-test data were included.

As shown in Table 33, there was no change on any attitude over the one-year period. This lack of change in responses may have been in part due to the similarity of supervisor opinions to ideal opinions on the pre-test. It will be recalled that scoring on each attitude was done by summing the absolute deviations of observed responses (Strongly Agree = 1, Agree = 2, Disagree = 3, Strongly Disagree = 4) from the ideal advocacy response (Strongly Agree or Strongly Disagree) across the three items to each attitude. The maximum deviation which could be achieved for an attitude given opposite pole responses to each item of the attitude was nine points, or a score of 90 points across the 10 attitudes. From Table 33 it will be noted that on the pre-test, the mean total score was 32.27, or an average deviation of about one point for each of the 30 attitude items. Operationally this means that on the pre-test, supervisors were typically saying "Agree" where a "Strongly Agree" response was the ideal, or "Disagree" when a "Strongly Disagree" response was the ideal. With the often found hesitancy of respondents to check the extreme ends of attitude scales, this suggests that supervisors had a close to ideal set of attitudes on the pre-test. Another interpretation in keeping with attitude change literature is that they were able to discern the socially desirable pole of each item and responded on this basis on both the pre and post-tests.

6. Advocate Health Opinion Survey

Advocates took the Health Opinion Survey immediately after training and then again one year later. Their responses to the first and second post-test administration are given in Tables 34 and 35 respectively. Pre-post comparisons were handled in two ways. For 61 Advocates, there were complete data, i.e., pre-test plus immediate and delayed post-test. For an additional 34 Advocates, pre-test and delayed post-test but not immediate post-test data were available. The responses of the 61 Advocates for whom complete data were available were contrasted in one way Analysis of Variance applied to each attitude score and the total score (see Table 36). There was an increase in compliance (decrease in deviation from ideal) on the first attitude, "Health issues can be grasped by non-health personnel". This increase in compliance occurred immediately after training and persisted throughout the year following training. The significant decrease in the deviation on the ninth attitude, "It is appropriate to foster independence rather than encourage dependency" was not accompanied by significant pairwise differences among means. Finally, there was a significant decrease in the total deviation score immediately following training. These results were essentially mirrored in the second analysis performed only on the pre-test versus one-year post-test data of the 95 Advocates for whom these data were available (see Table 37). Again, the lack of change is notable, with the compliance of Advocates relatively high on the pre-test, as had been the case for supervisors.

To explore more fully where the changes had occurred, responses to each item of the scale were examined. Pre-test responses to each item were contrasted with first post-test responses across the 73 Advocates for whom these data were available. The results of these analyses are given in Table 38. There was significant change on five of the 30 items, which was more than would be expected by chance alone for $\alpha = .05$. All changes observed were in the direction of greater compliance on the post-test. The five attitude items for which significant change was noted were as follows:

Item 2: Most people know as much about their own health as a doctor can find out in an examination. (Ideal Answer--Strongly Agree) — Attitude 1

Item 3: People who aren't trained professionals should not give advice on health. (Ideal Answer--Strongly Disagree) — Attitude 1

Item 11: If a person has success rather than failure at one task, s/he is more likely to succeed on a harder task. (Ideal Answer--Strongly Agree) — Attitude 4

Item 15: No one but a parent should know a child's personal health history. (Ideal Answer--Strongly Disagree) — Attitude 5

Item 27: It is best to let people do as much as they can for themselves. (Ideal Answer--Strongly Agree) — Attitude 9

In sum, there was some evidence of change in the direction of compliance on the Advocate Health Opinion Survey. The change occurred primarily on Attitude 1, "Health issues can be grasped by non-health personnel", for which there was change on two of the three items used to tap the attitude. As is clear from pre-test data present in Tables 36 and 37, it was this attitude for which deviations from ideal were greatest on the pre-test.

7. Advocate Health Knowledge Test

Responses to the Health Knowledge Test (HKT) immediately after and one-year after training are given in Tables 39 and 40 respectively. There were 81 Advocates for whom complege data (pre-test, first and second post-test) were available. The three HKT administrations were contrasted with one-way Analysis of Variance applied to each Item Cluster Score (see Table 41). There was a significant gain from pre to first post-test on all Item Cluster Scores. One year after training all scores still remained above those of the first pre-test. For the scores of two Item Clusters, 3 and 7, there was a decline in scores from immediate to delayed post-test, though the final post-test scores remained above those of the pre-test. Overall, there was approximately 50% accuracy on the pre-test, with close to 75% accuracy on both post-tests, indicating a substantial gain in health knowledge following HAT.

There were 13 additional Advocates for whom pre and one year post-test data but not immediate post-test data were available. A second analysis was run on only the pre and delayed post-test data which analysis included these additional 3 Advocates. As seen in Table 42, these results mirrored those presented in Table 41.

8. Overview of Pre-Post Change

There was a reliable increase in compliance in all areas of Health Standards for programs which participated in HAT. Changes in Advocate role were most marked in the area of the nature of their involvement. Advocates moved toward an advocacy model--less often performing activities themselves while more often combining performance of activities with advocating of those same activities. Overall, Advocates became involved in more activities after training. They reported greater awareness of the contents of the health component, and attributed this gain in knowledge to HAT. There was evidence of change in only a few attitudes of Advocates as measured on the Health Opinion Survey with no change noted in supervisor opinions. This seemed in part due to the relatively high level of compliance on the pre-test. Finally, there were substantial gains in knowledge about health with little loss in knowledge over the year following training.

READERS NOTES

D. CHANGE IN HSCC AS A FUNCTION OF CHANGE IN OPINIONS, KNOWLEDGE AND ROLE

This section describes the change in compliance with health standards measured on the HSCC, as a function of change in Advocate Opinion, Knowledge and Role. Change was considered separately for each HSCC scale, and for the two subscales of the First Aid Scale.

Measures of Opinion, Knowledge and Role were taken from the remaining tests in the battery.[4] These measures were conceptually divided into five areas. These areas, plus the scores which fall into each area are summarized below.

MEASURES EMPLOYED IN THE ANALYSIS OF GAIN ON THE HSCC
(Abbreviations of the Measures are Given in Parentheses)

Conceptual Category	Specific Measures
Advocate Opinion	1. Total Deviation Score from Advocate Health Opinion Survey (OPIN)
Advocate Knowledge	2. Total Score from Health Knowledge Test (HKT)
	3. Percent of Activities which Advocate reports s/he is aware are part of the health component (INF, from Role Form)
Involvement of Advocate in Health Component	4. Percent of Activities in which Advocate is involved (INV, from Role Form)
	5. Total Advocacy Score (TADV, from Role Form)
Lack of Involvement of Advocate in Health Component	6. Percent of time spent on non-advocacy related activities (NONAD, from Role Form)
	7. Percent of activities for which someone else is responsible (ELSR, from Role Form)
Administrative Input	8. Advocate listed versus not listed as involved in internal planning of the health component (ADVLS, from HSCC Item 60)
	9. Percent of activities for which Advocate or Advocate and supervisor make mutual decision that activity will be performed (INAM, from Role Form)
	10. Percent of Activities blocked administratively (ADB, from Role Form)

[4] One measure of Advocate role was taken from the HSCC.

1. Calculation of Adjusted Change Scores

For each measure, adjusted, rather than raw change scores were employed. The adjustment in each change score was that pre-test level was controlled (partialled out). Change scores are typically related to pre-test scores in that low pre-test scores are associated with greater potential gain than are high pre-test scores. Therefore, it is desirable to examine measures of change which are unconfounded by pre-test levels.

Change scores were adjusted in the following series of steps:

a. Gain scores (post minus pre) were computed.

b. Gain scores were predicted from pre-test scores in a univariate regression analysis.

c. Residuals of the form actual gain minus gain predicted from pre-test were calculated.

The residuals calculated in step c are measures of gain which are independent of the pre-test level. It is these measures that were used in the present series of analyses.

Correlations among the adjusted gain scores of the measures listed in Table 42 are given in Table 43. Similar correlations among adjusted change scores on the various HSCC scales are given in Table 44.

2. Computation of a Total Change Score

It was desirable to have a summary measure of total gain on the HSCC. Such a measure was calculated by summing the adjusted gain scores across all HSCC scales. This total measure gives equal weight to all areas of the health component, independent of the number of items on the HSCC employed to tap the area of the health component. Weighting individual items was considered but rejected on the basis that the relative importance of compliance with individual items in terms of avoidance of risk to child health is not known.

3. Relationship of Gain on HSCC to Other Measures

Correlations of the ten opinion attitude and role measures with HSCC Scale Scores are given in Table 45. Some surprising correlations emerge. Large amounts of blocking of activities by administrators was associated with greater gains in Health Services Screening and Dental Care. Medical Records Process scores were higher for programs in which the Advocate had little input into the decision as to whether the activity should be performed. These functions represent administrative and clerical responsibilities for which most day care programs require interaction, negotiation or, at the least, communication with outside agencies. Such outside linkages are likely to be more effectively accomplished by administrators who are free to use their leadership and fiscal control status in such matters than by Advocates who must be more tentative about their authority.

3. Relationship of Gain on HSCC to Other Measures (Cont'd)

Three measures are positively associated with overall gain in compliance with Health Standards. These are the percent of health related activities in which the Advocate is involved, the level of non-involvement of the Advocate occasioned by someone else being responsible for particular parts of the health component, and finally, that the Advocate is involved in planning the health component. In each instance, the measure represents active commitment on the part of the program to achieve the prescribed standards. Since advocacy is basically "seeing to it" that things are done, all three measures may be considered desired outcomes of advocacy.

4. Prediction Analyses

a. Description of the Analyses and Data Display

The relationship between gains on measures of Opinion, Attitude and Role and gains on the HSCC were examined in a series of regressior analyses. In the series of analyses, the various HSCC subscale adjusted gain scores and the total HSCC adjusted gain score served as dependent measures in separate regression analyses. In the series of analyses, predictors were entered in a typical unconstrained stepwise build-up procedure. The best variable, i.e., the one most highly correlated with each variable was entered first. After this, the second variable entered was that variable which added the most prediction to the equation, given the predictability of the first variable. This procedure of choosing the best predictor on each step, given the preceding variables already entered, was continued until all predictors were included. The result of the series of analyses is given in Table 46. A brief explanation of the way in which the data are displayed in Table 46 is offered to help the reader.

There are four rows of information in Table 46 concerning each scale. The External Planning Scale will be used as an example to explain each of the four rows.

The first line of the analysis for each variable is labeled "Variable Entered". In stepwise build-up analyses, the order of entry of variables is determined by both the correlations among the predictors and the correlation of each predictor with the criterion. As the dependent variable changes from analysis to analysis this order of entry changes. For External Planning, the Health Opinion Survey is the best predictor. Hence it enters the regression equation first. Given that Health Opinion is entered, the Total Advocacy Score (TADV) is the next best predictor and is entered second. Given OPINION and TADV in the prediction scheme, the variable INAM contributes the most predictability of the remaining variables and is entered in Step 3. The addition of variables continues until all variables are entered or until a step is reached at which the variables which have not yet entered into the equation contribute nothing to prediction (have multiple partial correlations of less than $\pm$ .01 with the criterion).

The second row, labeled R^2_{mult}, gives the squared multiple correlation after each variable is entered. In general, R^2_{mult} measures the proportion of variance in a dependent measure accounted for by a set of predictors, or the extent to which the predictors are informative about (related to) the dependent variable, in this case the External Planning Score. Reading across the R^2_{mult} row of External Planning in Table 46, .066 is the proportion of variance accounted for by the Opinion Test alone; .115 when both Advocate Opinion (OPIN) and Total Advocacy (TADV) are included in the prediction scheme; .141 when Opinion, TADV and INAM are in the prediction scheme. In sum, the R^2_{mult} row shows the accummulation of prediction as each new variable is added to the equation. Tests of significance are reported for the various R^2_{mult} values reported in the second row of the analysis. If R^2_{mult} is significant, this means that there is better than chance predictability that the set of predictors combined to result in the particular R^2_{mult}.

The third row is labeled Proportion Gain. This row indicates how much increase in predictability there is when each new variable is added to those already in the equation. Still considering External Planning, consider the column labeled TADV, the Total Advocacy Score. In the third row of External Planning, the number .048 appears; this number indicates that the proportion of predictability gained by adding TADV to a prediction scheme including all prior variables, i.e., Opinion. In the next column labeled INAM, the number in the third row is .026, which is the proportion of predictability gained by adding INAM to a prediction scheme already containing the prior variables OPINION, and TADV. Thus, the third row of the table gives the build-up in predictability on an individual variable contribution basis.

The fourth row labeled b* also concentrates on the individual variables. The measure b* for a variable gives the weight or importance of a variable in a prediction scheme. It is the absolute value of this weight which is critical for considering the relative contribution of certain variables to the final prediction. Hence, a variable with a weight of -.270 contributes more than a variable with a weight of +.103. The sign of the weight indicates the direction of the relationship, as in more familiar correlations. The weights for any variable depend on all other variables included in the regression scheme. Still considering the External Planning analysis, it should be noted that b* weights are given only for the first four variables. This is done because prediction was not substantially increased by adding any variables beyond the first four.

In general, in any stepwise regression analysis, the analysis may be cut off with any number of variables in the analysis. The choice of the number of predictors to retain in the final analysis is determined by picking the variables which contribute to prediction, while eliminating those which contribute no predictability. In Table 46, the b* weights given for the first four variables are derived from the fourth step analysis when only OPIN, TADV, INAM, and HKT are included in the prediction scheme. Tests of significance are provided for each of the b* weights. If a particular b* is significant, this means that the variable in question contributes a significant amount of the total predictability measured in R^2_{mult}.

In general, for any analysis, choice of the step, i.e., number of variables entered, at which to report b* weights for any analysis is somewhat subjective. The following criteria were employed in choosing the reported step:

1) If there was the significant overall predictability, i.e., R^2_{mult} was not significant for any step, the two predictor equations were arbitrarily reported unless a b* became significant when additional variables were added. For Internal Planning, First Aid and Routine Transportation, this two variable rule was followed. For the Percent Trained in First Aid, the predictor ELS was significant in the four variable, but not the one, two or three variable equation. Hence, the four variable equation was reported.

2) If the proportion gained by an additional variable was approximately .02, the variable was included, whether or not the weight for that particular variable was significant. This rule accounted for the presence of the third and fourth variables on the External Planning Scale, the third variable on Health Services Screening, the second and third variables on Medical Evaluation and Treatment, all variables on Health Policies and Procedures and the First Aid Equipment Subscore, the fourth variable on Health Education, the second variable on Dental Care, the second and third variable on Nutrition, and the fourth variable on Total Adjusted Change.

3) If the presence of non-significant variables in an equation led to the significance of other variables, the non-significant variables were included. This accounts for the presence of the third and fourth variables of Special Needs, the third variable of Staff Health, the second through fourth variables of Emergency, Evacuation and Disaster Plans and the fourth through sixth variables on Medical Record Content.

In sum, these rules were employed to best display the patterns of significant results in the data. The patterns of prediction for each scale score are summarized individually in the following narrative.

There were three scales for which there was no significant prediction. These were the Internal Planning Scale, the First Aid Scale and the Routine Transportation Scale. Significant predictors were found for each of the other 15 scales examined as well as for the Total Adjusted Change Score.

b. Results of the Prediction Analyses Where Significant Predictors Were Found

1) External Planning

As shown in Table 45, adjusted gain in External Planning is associated with a gain in compliance of attitudes measured on the Health Opinion Survey,[5] and a gain in knowledge measured on the HKT. Surprisingly, however, there is a negative relationship between External Planning and Total Advocacy. In the Regression Analysis shown in Table 46, the Opinion Score and the Total Advocacy (TADV) Score are significant predictors of External Planning. The unexpected negative relationship may be explained by the fact that TADV indicates the amount of activity of the Advocate in seeing to it that the health component is adequately provided. To the extent that the Advocate has mobilized other people to become involved in the health component, the program may not perceive as much need for external sources of expertise to be involved.

2) Special Needs

Adjusted gain on the Special Needs Scale is predicted from two measures, one reflecting the involvement of the Advocate, the other reflecting the involvement of other people than the Advocate in providing the health component. That the Advocate is among the people involved in planning the health component is positively related to gain on the Special Needs Scale as is the level of involvement of others in providing the health component.

3) Health Services Screening

There was an unexpected positive relationship between gain on this scale and the amount of blocking of activities by administrators. The other significant predictor of gain was the involvement of people other than the Advocate in health component activities. This suggests that in programs where administrators block Advocates from providing or arranging for screening tests themselves, this action is due to there being other staff members who are designated to provide screening tests or who see to it that screening tests are provided.

4) Medical Evaluation and Treatment

For this scale, as well as the previous two scales, the involvement of people other than the Advocate is critical for compliance with the provision or arrangement of medical evaluation and treatment services. While the Total Advocacy Gain Score (TADV) is significantly correlated with this HSCC Scale Score, it is not a significant predictor in the equation containing the measure (ELS) of the involvement of others (see Table 46). This would be expected from the fact that TADV and ELS are themselves positively correlated. In programs where the Adovcate is actively involved in health component activities others are also active.

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[5] The Health Opinion Survey is scored such that high scores indicate non-compliance. Hence, a negative correlation between Opinion Scores and Scale Scores is in the expected direction and indicates increased compliance on both the Opinion Survey and Scale Scores.

5) Medical Records Process

From the pattern of prediction of gain on this scale it appears that the input and control of supervisors is critical. Gain on this scale is a negative function of the administrative input of the Advocate and a positive function of the extent to which the Advocate is blocked from his own personal involvement. Moreover, gain on this scale is associated with extent to which other people are responsible for considering medical records. The only input from the Advocate seems to be in his involvement in planning the whole health component, of which the handling of medical records is a part. Considering the four predictors together, they suggest a process in which the Advocate points out the concern with medical records and the administration responds by designating staff members other than the Advocate to handle medical records. This finding is consistent with the fact that the majority of the Advocates have other roles (principally social service and educational) which prevent them from being solely responsible for the clerical and administrative tasks related to handling of medical records.

6) Medical Record Content

Gains on this scale were a positive function of the Advocate's gain in knowledge of the health component (HKT) and of the extent to which others were involved in the activities of the health component (ELS). An unexpected result, and one that is not easily interpretable substantively is that gains in the adequacy of medical records was also a positive function of the extent to which Advocate's Opinions (OPIN) deviated from the ideal advocacy profile. There is a statistical, rather than substantive reason for this result: the OPIN score acts as a suppressor variable in the prediction scheme. Hence, the significant positive regression coefficient for OPIN should be interpreted as a purely statistical phenomenon rather than a true correlation between Advocate's not holding desired opinions and the adequacy of medical records.[6]

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[6] A suppressor variable is one which is correlated with other predictors but which is not correlated with the criterion. A suppressor variable increases prediction through its correlation with another significant predictor, by controlling the error of prediction in the significant predictor. Consider the formula for the standardized regression coefficient b* in a two predictor case:

$$b^*_2 = \frac{r_{y2} - r_{y1} r_{12}}{1 - r^2_{12}}$$

where r_{y2} is the correlation of predictor 2 with the dependent variable y

r_{y1} is the correlation of predictor 1 with the dependent variable y

r_{12} is the correlation between the two predictors

Even if r_{y2} is small, as in the case of the .13 co-relation between the OPIN Score and the Medical Records Content Score, if r_{12} is large in absolute value, as here with $r_{12}=-.41$ for the correlation between HKT and OPIN, the regression coefficient for variable 2, here OPIN, will be large in absolute value and be significant.

7) Health Policies and Procedures

There are increases in prediction of adjusted gains on this scale as the first three predictors (ADVLS, INV and ELS) are added to the prediction scheme. However, when all three predictors are included, no single predictor is significant (see Table 46). The fact of the Advocates being involved in planning the health component (ADVLS) is a significant predictor when only this variable is used to predict gain in compliance on this scale. That the trained Advocate's being involved in planning is associated with gains in compliance on this scale is reasonable in view of the heavy planning component involved in developing adequate health policies.

8) Health Education

In terms of first order correlations, Advocate's gain in knowledge of the health component measured by scores on the HKT and by his own reports of the extent of being informed of the health component (INF) is positively correlated with gains in compliance with Health Education standards. The extent of the Advocate's involvement with the health component (INV) is also positively correlated with gains on this scale (see Table 45). In the prediction scheme (Table 46) both INF and INV are significant predictors of compliance (HKT is not, as it is significantly correlated with INF and is hence redundant with INF). Once again, the extent of administrative blocking of the Advocate's own involvement is positively, rather than negatively correlated with gains in compliance on this scale. As with previous cases in which this is so, this result can be interpreted to indicate an active role on the part of the administrator in establishing health education as part of the program's health component.

9) Staff Health

The best predictors of this scale are, as in previous cases, measures which suggest that staff members other than the Advocate himself are critical here. High levels of involvement of other people coupled with low input of the Advocate as to whether staff health activities will be pursued are associated with increased compliance on this scale.

10) Emergency Evacuation and Disaster Plans

The involvement of people other than the Advocate was the only significant predictor of gain on this scale. As with other scales discussed above, programs where responsibilities are shared by others, even if brought into the program by the Advocate can be expected to do better than programs where the Advocate is left to do everything on his own.

11) Percent Trained in First Aid

As in the previous scale, involvement of others was the only significant predictor of gain on this scale.

12) Equipment Subscore--First Aid Scale

The measure of gain in Advocate involvement (INV) plus measure of gain in Advocate's knowledge (INF) were both significantly correlated with gain on this subscale (see Table 45). While these two measures plus Advocate Opinion (OPIN) led to increased prediction of gain on this scale, none was a significant predictor in the three predictor case. INV was, however, a significant predictor only when it alone was used to predict gains on this subscore. Maintenance of first aid equipment could be expected to be delegated to the Advocate and best performed by Advocates who are knowledgable both about the need for equipment and about the type of equipment needed.

13) Dental Care

The prediction of gain on the Dental Care Scale followed a pattern similar to that for the prediction of Health Services Screening, Medical Records Process and Staff Health in that gains in this scale were positively, rather than negatively related to the degree of administrative blocking. Moreover, the best predictor of gains on this scale, given the inclusion of the Administrative Blocking Scale, was the extent to which people other than the Advocate were responsible for the activity (ELS). The reason for this finding is presumed to be similar to that offered for the other scales where this relationship occurred.

14) Nutrition

Again, prediction of gains on this scale followed a pattern similar to that on the Dental Care Scale, with the involvement of others (ELS) the best predictor, and Administrative Blocking the second best.

15) Environmental Quality and Safety

Gains on this scale were associated directly with Advocate activity, being best predicted by the measure of overall involvement of the Advocate in the activities of the health component (INV). Accidents are the most frequent cause of death of children after the neonatal period. Since so much of health in children relates to the safety of the environment, the involvement of the Advocate with gains viewed as an important contribution to the promotion of child health.

16) Total Adjusted Change

The prediction of the Total Adjusted Change Score yields perhaps the clearest picture of the role of the Advocate in improving the health component of the Project. Overall gain in compliance was most highly correlated with programs' including the Advocate among people involved in planning the health component (see Table 45). Gain on this scale was also significantly correlated with increases in involvement of the Advocate in activities of the health component (INV), as well as the involvement of others (ELS). These three measures were all significant predictors of the Total Adjusted Change in compliance with health standards.

5. Summary of Part D

Some rather surprising but informative results emerge from the series of prediction equations reported. The most startling on the surface is that when the supervisor of the program blocks the Advocate from being involved in a health component activity, this blocking does not imply that there is lack of compliance by the program with health standards. On the contrary, in several cases compliance with health standards improved when administrative blocks increased. Further, sometimes there was a gain in compliance when the supervisor made the decision that an activity would be performed without input into the decision from the Advocate. There is also the recurrent result that the extent to which people other than the Advocate become involved in providing the health component is positively related to gains in compliance. What these results suggest is that the Advocate's role is to increase the awareness of health issues at the day care site. As input to the health component from a variety of people including the supervisor increases, the health component improves.

How then is the Advocate or the HAT process involved in improving the health component? The Role Form provides some information here. From pre to post-testing, there was an overall increase in the involvement of the supervisor in deciding about the health component. This suggests that the monitoring provided by the HAT evaluations plus the presence of a trained staff member spurred the supervisor's concern about his program's health component. Further, there was a decrease in failure to provide aspects of the health component due to simple lack of planning coupled with an increase of both the Advocate's and others becoming responsible for various aspects of the health component. In addition, the fact of the Advocate's having input into planning the health component and in being involved in the health component himself, was related to the degree to which the programs improved.

E. EXAMINATION OF THE EFFECT OF EVALUATION

The original design of the Project called for a comparison of sites which were pre-tested, trained and re-tested one year later with a set of sites which were pre-tested and post-tested at the same time as the former sites, but were not trained. The purpose of the design was to assess the impact of evaluation or monitoring alone versus evaluation plus training on improvement in the health component. A considerable amount of information about the health component may be gleaned from merely experiencing the administration of the HSCC instrument. For program supervisors, the administration of the HSCC may well direct the supervisor's attention to areas of lack of compliance in his own program. His awareness of lack of compliance in turn may lead him to attempt to correct the deficiencies in his program.

Cycle E/F was tested, not trained and re-tested one year later. The scored data from the evaluations were not shared with the sites until after the data from the last evaluations were scored. These evaluations spanned the same time period as the pre and post evaluation of Cycles A, B and C. Gain from first to second testing in Cycle E/F was thus compared with that of Cycles A through C.[6] Comparisons were made separately on each of 32 HSCC indices.[7] By way of review, on 22 of the 32 HSCC indices, each program is assigned a score on each administration. There are 10 indices for which no score may be assigned under certain conditions. There are four indices of Special Needs which are not scored when a program has no special needs children, (Indices 2 through 5 of Table 47). Two subscales of the Health Services Screening Scale (Indices 11 and 12 of Table 47) are not scored if the program provides no screening tests. Similarly, three subscales of the Medical Evaluation and Treatment Scale are not scored if the program provides no Medical Evaluation and Treatment (Indices 15, 16 and 17 of Table 47). Finally, the Routine Transportation Scale Score is deleted if the program provides no routine transportation (Index 30 of Table 47).

Three analyses were run on each HSCC index. First, each index was analyzed with an unweighted means analysis of variance contrasting Cycles A, B and C versus E/F as Factor 1 (groups) and pre versus post as Factor 2 (pre-post). Significance of the group main effect would indicate overall group differences between Cycles A, B and C versus E/F. Significance of the pre-post main effect would indicate similar profiles of change for both groups of cycles. Significance of the two-factor interaction would, in contrast, indicate differential change in the two groups of cycles.

The second analysis further explored possible differences in gain in Cycles A, B and C versus E/F. This analysis consisted of a planned comparison (t-test) contrasting change (post minus pre) in Cycles A, B and C versus E/F.

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[7] Cycle C contained a family day care program consisting of five sites. These sites were eliminated from analysis since no such family home sites appeared in Cycle E/F.

The third analysis was an adjusted change score analysis. Change scores (post minus pre) were calculated for each site. These change scores were then predicted in a linear regression equation from the pre-test scores. The residuals (observed change minus predicted change) from this regression analysis then served as measures of change which were independent of pre-test level. The residuals from Cycles A, B and C were contrasted with those from E/F with a t-test to examine whether adjusted gain was greater in Cycles A, B and C or E/F. This third analysis was required to control for pre-test differences which might exist between the groups.

The loss of cases from pairwise deletion on the 10 indices described above is small to moderate. In all, there are 54 cases (sites) in combined Cycles A, B and C and 17 in E/F. For delete indices 2, 3, 4 and 5 (Special Needs), there were 49 and 15 complete cases respectively. For delete indices 11 and 12 (Screening) there were 43 versus 11 complete cases respectively. For delete indices 15 through 17 (Medical Evaluation and Treatment) there were 44 versus 12 complete cases respectively. For delete index 30 (Routine Transportation) there were 53 versus 16 complete cases, respectively.

The pre and post means and standard deviations of each group on each index are summarized in Table 47. Table 48 summarizes the results of the three types of analysis for each index. This table shows significance levels for the Analysis of Variance effects, and the t-values for the planned comparison and test of residuals. For t-values, a positive t-test indicates that Cycles A, B and C showed greater improvement than Cycle E/F; a negative t-test, the converse. Significance levels for t-tests in Table 48 are two-tailed values, since it was possible that a reverse effect, i.e., greater gain in Cycle E/F than in A, B and C might occur.

The most appropriate analysis for the comparison of Cycles A, B and C versus E/F is the adjusted change analysis. On 5 of the 28 indices on which compliance may be shown (indices 3, 4 and 5 merely count the occurrence of special needs), Cycles A, B and C began or tended to begin at significantly higher compliance levels than Cycle E/F. On other scales there were substantial pre-test differences, though these differences did not reach significance due to large, within group variability levels on the pre-test, as shown in Table 47. It must be noted here that some sites selected themselves into Cycles A, B and C versus E/F by their eagerness to participate in training immediately (Cycles A, B and C) versus to hold off training for at least a year (Cycle E/F). Whenever self-selection rather than random assignment to groups occurs, pre-test differences between groups may be expected. Statistical correction for such differences, as accomplished by the adjusted change score analysis, is required before change in one versus another group can be appropriately compared. For this reason, the discussion of Cycles A, B and C versus E/F change will consider the residuals test on adjusted change scores given in the last two columns of Table 48.

The direction of differential gain was quite consistent over indices. Discounting scales 3 through 5 which simply enumerate the occurrence of special needs, in 25 of the 29 scales adjusted gain was greater in Cycles A, B and C than E/F. On scales 1, 9, 11 and 30, there was less gain in Cycles A, B and C than E/F though this reversal was substantial for only index 11, the Health Services Screening Consent Score. The adjusted gain was significantly greater for Cycles A, B and C over E/F in 10 of the 28 compliance scales suggesting that collectively, the greater gains noted for Cycles A and B might well not be considered

to be due to chance alone. Of the 32 indices, 16 are major scale scores. Significantly greater gain or a tendency to greater gain for Cycles A, B and C over E/F was noted in 7 of these 16 scales. These scales are Health Services Screening, Medical Evaluation and Treatment, Health Policies and Procedures, Health Education, Dental Care, Emergency Evacuation and Disaster Plans and First Aid.

One might inquire as to the reasons for any improvement in Cycle E/F. There was a significant pre-post main effect on 16 of the 28 compliance scales and a tendency to such an effect on two other compliance scales, indicating increased compliance in both Cycles A, B and C and E/F. A major reason for E/F gain is likely to be the impact of testing. The pre-test may well have cued the programs to potential areas of health component improvement.

Other reasons are suggested throughout the literature of field research, e.g., (a) increased facility of the interviewers on post over pre-test which led to better elicitation of responses on post-tests; (b) changes in coding criteria for procedure adequacy; (c) a health oriented Zeitgeist appeared in the field due to the increasing presence of trained sites or improved resources throughout the City of Philadelphia. Reason (a) is a possible contributor to the E/F gains. Reason (b) is not likely since all coding was done in strict adherence to a coding manual. Where any changes in coding criteria were instituted over time, data which had been previously coded were recoded by the updated standards. Reason (c) seems to be refuted by the test of the spread or influence hypotheses performed on pre-test data and described in an earlier portion of this report.

There are some interesting patterns which emerge when change on particular scales is considered. The significant pre-post main effect ($p < .001$) on index 9 dealing with provisions of screening tests indicated that for both groups of sites, more sites offered at least some screening tests at the second evaluation over the first. Further, the pre-post main effect for the Health Services Screening Scale Score ($p < .001$) indicated that both groups of sites improved in the quality and quantity of the screening services provided. However, this gain was significantly greater for the trained groups (Cycles A, B and C) than for the untrained group (Cycle E/F). Apparently, testing alone was sufficient to indicate to programs that they should provide screening services. The adequacy of the screening services provided by the program depended upon whether their Advocates were trained. A similar pattern emerged for Medical Evaluation and Treatment Scale. The importance of this analysis is in determining in which areas significant improvement in health component compliance can be expected by monitoring alone and where HAT training is insufficient to boost this effect, i.e., External and Internal Planning and dministration, pecial eeds, content of Medical Records, Nutrition and Transportation. This finding may mean that other types of training or other changes in program variables (e.g., increased funding, removal of barriers to compliance) are required to raise compliance beyond that achieved by increasing the program's awareness of standards. On the other hand, the areas in which training did improve compliance over that achieved by monitoring for compliance are targets for continued emphasis in training areas.

In sum, on a large number of HSCC indices, both the cycles which were evaluated and which had trained Advocates (A, B and C) and those which had only been evaluated (E/F) improved. However, on almost half of the main HSCC scales, there was differential improvement with sites having trained Advocates showing greater improvement than those sites without trained Advocates. Monitoring alone led to increased compliance; however, in a substantial number of health component areas, training increased compliance over that occasioned by monitoring alone.

F. ADDITIONAL STUDIES WHICH COULD BE PERFORMED ON HAT DATA

There are a number of analyses which are relevant to the interpretation which were not completed by the time of this report. These analyses include:

1. An inspection of trainee application data to examine whether there are selection factors which influence the particular Advocate who remain in versus those who drop from the HAT Project.

2. An examination of the relationship of Advocate characteristics, training and experience to the effectiveness of the Advocate in effecting gains in compliance in day care programs.

3. As part of the A,B,C versus E/F comparison, subcomparison of "near" (E) sites versus "far" (F) sites would show the effects of geographical location on possible "rub-off" of training in other programs. In addition, comparisons of the health knowledge, role and opinion data for Cycle E/F with those data from Cycles A, B and C might lend some clarity to the way in which compliance improved by virtue of monitoring alone.

4. In general, the programs which participated in HAT and their constituencies may be stratified on a number of variables which are expected to be related to gains in compliance. Preliminary analyses of this type performed for local agency use suggests some relevant stratification variables. Among these variables are:

   a. Population served, considered in terms of SES, age, disabled versus non-disabled, type of age grouping (homogeneous versus heterogeneous), ethnic mix.

   b. Program characteristics, considered in terms of program site location (center city versus suburban), type of program (family versus center), type of funding of the program as a whole, per-child spending on health related budget items, hours of operation (part-day versus full-day operation), program size.

   An inspection of Table 11 (Program Demographics) plus Tables 10 and 25 (Trainee Application) indicates that there is sufficient range on these variables for such stratifications to be considered.

5. Medical record content data could be examined to determine which health services are most and least adequately provided or arranged for by day care programs. This type of analysis could also be coorelated with other variables described above to obtain a better picture of service needs.

The battery of analyses required to answer the questions implied in the list of potential stratification variables is complex. It would necessarily require a close consideration of correlations among stratification variables, as well as between stratification variables and compliance criteria. These analyses are complex and require careful interpretation of the results. Although preliminary analyses of these types were reported to local agencies for their own use, the time required to perform them on final data was not available within the Project period. If there is interest and funding available, the suggested comparisons and analyses can be performed.

In addition to these analyses, which are confined to the day care program population of the HAT Project, there are data gathered by HAT which show the interface between programs and health service delivery agencies in the community. These data can be used to describe day care program utilization of health service providers in an urban setting which are to be provided on a nationwide basis, e.g., health providers who offer Early Periodic Screening and Diagnostic Treatment services. Preliminary analysis of these data reveal patterns of utilization which might also be correlated with other variables studied by the Project. Again, these correlations require complex analyses which could be performed with additional time and funding.

TABLES FOR SECTION IV

TABLE 10

SUMMARY OF TRAINEE APPLICATION INFORMATION
PRE-TRAINING DATA

	Pilot	A	B	C	D	G	E_2[a]	F_2[a]	E/F_N	Total
AGE OF TRAINEE										
Number Responding	14	19	18	17	20	20	5	5	10	128[b]
Under 20	7%	0%	0%	0%	0%	0%	0%	0%	10%	2%
21 to 30	36%	47%	50%	47%	15%	20%	50%	40%	50%	37%
31 to 40	36%	26%	50%	23%	40%	30%	20%	0%	40%	33%
41 to 50	21%	21%	0%	23%	30%	35%	0%	40%	0%	20%
51 and Over	0%	5%	0%	6%	15%	15%	20%	20%	0%	8%
SEX OF TRAINEE										
Number Responding	14	19	18	17	20	20	5	5	10	128
Male	0%	16%	11%	0%	5%	10%	20%	0%	10%	8%
Female	100%	84%	89%	100%	95%	90%	80%	100%	90%	92%
MARITAL STATUS										
Number Responding	14	19	18	17	20	20	5	5	10	128
Single	7%	21%	44%	41%	10%	5%	80%	20%	40%	25%
Married	64%	58%	39%	41%	45%	65%	20%	80%	50%	52%
Divorced	0%	16%	6%	0%	15%	5%	0%	0%	10%	7%
Separated	29%	5%	11%	12%	15%	15%	0%	0%	0%	12%
Widowed	0%	0%	0%	6%	15%	10%	0%	0%	0%	5%

[a] E_2 and F_2 represent the E/F trainees whose data were collected just prior to training, E/F_N represents the new trainees who were not part of the original comparison group.

[b] Three pre-training trainee applications were found to be missing at the time of data tabulation.

TABLE 10--SUMMARY OF TRAINEE APPLICATION INFORMATION PRE-TRAINING DATA

	Pilot	A	B	C	D	G	E_2	F_2	E/F_N	Total
AGE OF OLDEST CHILD										
Number Responding	11	16	8	7	16	15	2	4	5	84
0 to 1 year	0%	6%	12%	0%	0%	0%	0%	0%	0%	2%
2 to 5 years	0%	12%	12%	29%	0%	7%	0%	25%	0%	8%
6 to 9 years	0%	6%	0%	0%	6%	0%	0%	0%	20%	4%
10 to 12 years	36%	19%	25%	14%	13%	7%	0%	0%	0%	15%
13 years and Over	64%	56%	50%	57%	81%	86%	100%	75%	80%	70%
AGE OF YOUNGEST CHILD										
Number Responding	11	16	8	7	16	15	2	4	5	84
0 to 1 year	0%	12%	12%	0%	6%	0%	0%	0%	0%	5%
2 to 5 years	36%	19%	25%	29%	13%	7%	50%	25%	20%	20%
6 to 9 years	45%	19%	25%	14%	31%	13%	0%	0%	20%	23%
10 to 12 years	9%	0%	25%	14%	6%	20%	0%	0%	40%	12%
13 years and Over	9%	50%	12%	43%	44%	60%	50%	75%	20%	40%
NUMBER OF CHILDREN										
Number Responding	14	19	18	17	19	20	5	5	10	127
0	21%	16%	56%	53%	21%	25%	60%	20%	50%	34%
1	7%	21%	11%	12%	11%	10%	20%	20%	0%	12%
2	7%	16%	11%	12%	21%	25%	20%	20%	30%	17%
3	14%	21%	11%	18%	21%	20%	10%	20%	20%	17%
4	21%	21%	11%	6%	5%	5%	0%	20%	0%	10%
5	7%	5%	0%	0%	5%	5%	0%	0%	0%	3%
More than 5	21%	0%	0%	0%	16%	10%	0%	0%	0%	6%

TABLE 10 (Cont'd.)

	Pilot	A	B	C	D	G	E_2	F_2	E/F_N	Total
HIGHEST ACADEMIC CERTIFICATION Number Responding	13	19	18	17	20	20	5	5	10	127
Grade 9 to 11	15%	5%	0%	0%	5%	0%	0%	0%	0%	3%
High School Graduate or GED	38%	37%	17%	18%	15%	10%	0%	20%	20%	20%
Some College	8%	21%	22%	29%	35%	55%	50%	0%	30%	30%
Associate Degree	0%	0%	6%	18%	5%	0%	0%	0%	0%	4%
Undergraduate Degree	18%	26%	28%	29%	25%	25%	30%	80%	40%	28%
Professional or Trade Certificate	31%	0%	17%	6%	10%	10%	20%	0%	10%	11%
Master's Degree	0%	5%	11%	0%	5%	0%	0%	0%	0%	3%
Dental Hygienist	0%	5%	0%	0%	0%	0%	0%	0%	0%	1%
NUMBER OF COLLEGE CREDITS (Of Those Attending But Not Finishing College) Number Responding	1	4	4	6	5	8	3	0	2	33
0 to 15 credits	0%	50%	25%	33%	50%	37%	33%	0%	50%	39%
16 to 30 credits	100%	25%	25%	17%	20%	0%	0%	0%	0%	15%
31 to 60 credits	0%	0%	50%	33%	0%	38%	57%	0%	50%	30%
61 to 90 credits	0%	0%	0%	17%	20%	25%	0%	0%	0%	12%
91 and Over	0%	25%	0%	0%	0%	0%	0%	0%	0%	3%

TABLE 10--SUMMARY OF TRAINEE APPLICATION INFORMATION PRE-TRAINING DATA

	Pilot	A	B	C	D	G	E_2	F_2	E/F_N	Total
NATURE OF HIGHEST DEGREES, CERTIFICATIONS, LICENSES HELD										
Number Responding	8	8	11	11	9	11	3	4	4	69
Child Development	12%	37%	18%	18%	11%	0%	0%	0%	0%	13%
Elementary Education	0%	0%	0%	9%	0%	0%	0%	50%	25%	6%
Secondary Education	0%	12%	18%	9%	0%	0%	33%	0%	0%	7%
Business	12%	12%	0%	9%	0%	0%	0%	0%	0%	4%
Nursing	63%	0%	27%	9%	11%	36%	33%	0%	0%	22%
Social Work	12%	12%	18%	18%	44%	45%	33%	25%	25%	25%
Liberal Arts	0%	12%	9%	9%	11%	18%	0%	0%	0%	9%
Psychology	0%	12%	0%	9%	11%	0%	0%	0%	25%	6%
Other [c]	0%	0%	9%	9%	11%	0%	0%	25%	25%	7%
NURSING CERTIFICATION										
Number Responding	14	19	18	16	20	20	5	5	9	126
Registered Nurse	14%	0%	11%	0%	5%	5%	0%	0%	0%	5%
Licensed Practical Nurse	0%	0%	6%	0%	5%	10%	20%	0%	0%	4%
No Nursing Certification [d]	86%	100%	83%	100%	90%	85%	80%	100%	100%	91%

[c] Cycle B and F_2 Sociology; Cycle C, Special Education; Cycle D, Home Economics; Cycle E/F_N, Psychiatric Art Therapy.

[d] Only 11 of 15 trainees reporting having nursing degrees reported having nursing certification as R.N. or L.P.N.

TABLE 10 (Cont'd.)

	Pilot	A	B	C	D	G	E_2	F_2	E/F_N	Total
CURRENT TITLE OF TRAINEE BY JOB CLASSIFICATION										
Number Responding	14	19	18	17	20	20	5	5	10	128
Administration: Director, Associate Director, Assistant Director, Program Administrator Supervisor	29%	16%	0%	29%	10%	15%	40%	60%	10%	18%
Clerical: Secretarial	0%	5%	0%	6%	0%	0%	0%	0%	0%	2%
Education: Teacher, Assistant Teacher, Teacher Aide, Child Care Worker	7%	37%	39%	23%	20%	5%	20%	20%	30%	23%
Social Service: Social Worker, Case Worker, Parent Contact Worker, Family Worker, Parent Coordinator, Social Service Worker, Social Worker Aide, Home Visitor, Social Service Coordinator, Social Worker Trainee.	29%	42%	44%	35%	60%	75%	40%	20%	60%	48%
Health: R.N., L.P.N., Health Coordinator.	36%	0%	17%	6%	105	5%	0%	0%	0%	9%
SALARY OF TRAINEE										
Number Responding	14	17	17	15	17	17	5	5	8	115
Less Than $5,000	21%	6%	6%	0%	6%	6%	0%	20%	0%	7%
$5,000 to $7,000	43%	71%	53%	33%	18%	6%	0%	20%	12%	33%
$7,001 to $10,000	36%	6%	18%	40%	76%	59%	80%	20%	63%	42%
$10,001 to $15,000	0%	18%	24%	27%	0%	29%	20%	40%	25%	18%

Table 10

TABLE 11

SUMMARY OF PROGRAM DEMOGRAPHICS - HSCC - PRE VERSUS POST (N= 142 PRE SITES, N= 125 POST SITES)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
001	Type of day care	Group or Family	10.6	8.0
		Center	89.4	92.0
		No response	0.0	0.0
002	Type of funding	Title IV-A	66.9	76.0
		Head Start	16.2	12.0
		Completely Private	5.6	5.6
		Mixed Govt. & Private	9.0	5.6
		Other	1.4	.8
		No response	0.0	0.0
003-008	Age Distribution: (each percent is percent of all programs with children of the particular age- one program gave no age distribution on pre test)	0-18 months	9.9	8.8
		19-35 months	24.6	28.0
		3-6 years	89.4	89.6
		6-8 years	30.3	29.6
		9-11 years	16.3	14.4
		12-16 years	.6	7.2
		No response	.7	0.0
009	Type of Age Grouping	Homogeneous	54.2	41.6
		Heterogeneous	45.8	58.4
		No response	0.0	0.0
011	Years of operation of program	Less than one year	10.6	1.6
		One year or more	89.4	98.4
		No response	0.0	0.0
012	Hours of daily operation of program	under 5 hours	4.2	.8
		5-5.9 hours	2.1	1.6
		6-6.9 hours	13.4	14.4
		7-7.9 hours	2.1	2.4
		8-8.9 hours	5.6	4.8
		9-9.9 hours	12.7	9.6
		10-10.9 hours	32.4	39.2
		11 or more hours	27.5	27.2
		No response	0.0	0.0

TABLE 11 (Cont'd.)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
013	Maximum number of child care places at site	10 or fewer children	9.9	7.2
		11-30	22.5	17.6
		31-50	35.2	36.8
		51-70	15.5	19.2
		71-90	9.2	9.6
		91 and over	7.1	9.6
		No response	.7	0.0
		(Median number)	40	45
014	Number of children registered for program	10 or fewer children	9.9	8.0
		11-30	25.4	16.8
		31-50	35.9	37.6
		51-70	16.2	20.0
		71-90	5.6	8.0
		91 and over	7.0	9.6
		No response	0.0	0.0
		(Median number)	39	43
015	Average monthly attendance	10 or fewer children	11.3	10.4
		11-30	35.2	29.6
		31-50	34.5	37.6
		51-70	4.2	9.6
		71-90	4.2	8.0
		91 and over	5.6	4.8
		No response	4.9	0.0
016	Maximum number of hours per day child in program's care	1-2.9 hours	2.1	1.6
		3-4.9	4.2	0.0
		5-6.9	15.5	17.6
		7-8.9	18.3	21.6
		9-10.9	46.5	44.8
		11-12.9	12.7	13.6
		13 or more hours	.7	.8
		No response	0.0	0.0
		(Median hours)	9	9

Table 11

TABLE 11--SUMMARY OF PROGRAM DEMOGRAPHICS--HSCC--PRE VERSUS POST

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE OR NUMBER	POST PERCENTAGE OR NUMBER
017	Minimum number hours per day child in program's care	1-2.9 hours	11.3	11.2
		3-4.9	23.9	21.6
		5-6.9	50.7	52.0
		7-8.9	12.7	12.8
		9-10.9	1.4	2.4
		11-12.9	0.0	0.0
		13 or more	0.0	0.0
		No response	0.0	0.0
		(Median hours)	5 1/2	5 1/2
018	Ethnic distribution of children in program (of White, Spanish American, and Black children)	White only (percent of programs)	6.3	3.2
		Spanish American only	0.0	.8
		Black only	35.2	36.0
		White & Spanish American	2.8	1.6
		White & Black	28.9	29.6
		Black & Spanish American	8.5	9.6
		White, Black & Spanish American	16.9	19.2
		No response	1.4	0.0
019	Of programs with Spanish American children, percent of those children who speak Spanish.	0-20%	20.0	17.9
		21-40	2.5	0.0
		41-60	0.0	5.1
		61-80	0.0	7.8
		81-100	77.5	69.3
		No response	0.0	0.0
020	Percentage of programs with children in ethnic categories other than White, Black and Spanish American	Percentage	21.8	24.8
		No response	.7	0.0
021-022	Of children in ethnic categories other than White, Black or Spanish American, percent of these children who speak their native tongue	0-20%	46.7	41.9
		21-40	6.6	9.7
		41-60	6.7	3.2
		61-80	0.0	0.0
		81-100	40.0	45.2
		No response	0.0	0.0

127

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TABLE 11 (Cont'd.)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE OR NUMBER	POST PERCENTAGE OR NUMBER
025	Years and months advocate has been employed in program	Less than one year	32.4	4.8
		1 yr.-1 yr. 11 months	13.4	21.6
		2 yrs.-2 yrs. 11 months	11.9	13.6
		3 yrs.-3 yrs. 11 months	18.4	10.4
		4 yrs.-4 yrs. 11 months	6.3	14.4
		5 yrs.-5 yrs. 11 months	7.0	9.6
		6 yrs.-6 yrs. 11 months	2.1	4.8
		7 yrs.-7 yrs. 11 months	.7	2.4
		8 yrs. and over	7.7	12.0
		No response	0.0	6.4

TABLE 12

SUMMARY OF RESPONSES TO HSCC ITEMS - PRE VERSUS POST (N= 142 PRE SITES, N= 125 POST SITES)

I. EXTERNAL PLANNING SCALE ITEMS (026-032)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
026	People reported as being involved in planning health component		84.5	98.4
027	Profession of at least one person given (of all programs)		84.5	96.8
	Frequency with which person works with program (of those programs reporting a person)	Once a year	11.0	2.5
		Twice a year	7.6	5.8
		Quarterly	11.9	5.0
		Monthly	69.5	84.3
		Unknown	0.0	2.5
028	One person identified who looks at whole health program		34.5	64.0
029	Date of person's visit given (of all programs)		31.7	63.2
	Profession of person visiting given (of all programs)		32.4	58.4
030	A program advisory committee on health has been formed		16.4	24.8
031	Of those reporting advisory committee, percent reporting regular meetings		87.0	71.0
032	Of programs reporting regular meetings, frequency of meetings	Once per year	10.0	0.0
		Semiannually	10.0	4.5
		Quarterly	15.0	13.6
		Monthly	65.0	63.6
		Never	0.0	0.0
		Unknown	0.0	0.0
		Uncodable	0.0	4.5

TABLE 12 (Cont'd)

II. SPECIAL NEEDS CHILDREN SCALE ITEMS (033-056)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
033	Programs reporting children with visual impairment		53.5	61.6
034	Number of children with visual impairment reported (of programs reporting children with visual impairment)	One	47.4	42.9
		2-10	46.0	53.2
		More than 10	6.6	3.9
035	Programs dealing adequately with visual impairment (of those having visually impaired children)		31.6	66.2
036	Programs reporting children with hearing impairment		26.8	32.8
037	Number of children with hearing impairment reported (of programs having hearing impaired children)	One	43.2	51.2
		2-10	51.4	48.8
		More than 10	5.4	0.0
038	Programs dealing adequately with hearing impairment (of programs having hearing impaired children)		15.8	78.0
039	Programs reporting children with physical disabilities		26.1	27.2
040	Number of physically disabled children (of those programs reporting physically disabled children)	One	51.4	47.1
		2-10	40.5	41.1
		More than 10	8.1	11.8
041	Percent of all programs which are MH/MR programs		7.7	9.6
042	For non-MH/MR programs, programs reporting having mentally retarded children		35.1	44.2
043	For non-MH/MR programs, number of retarded children	One	54.3	50.0
		2-10	41.3	42.0
		More than 10	4.3	8.0
045	For MH/MR programs only, number of mildly retarded children	0-5	54.5	41.7
		6-10	18.2	16.7
		More than 10	27.3	41.7

Table 12

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
045	For MH/MR programs only, number of moderately retarded children	0-5	27.3	33.3
		6-10	36.4	33.3
		More than 10	36.4	33.3
045	For MH/MR programs only, number of severely retarded children	0-5	54.5	58.3
		6-10	27.3	25.0
		More than 10	18.2	16.7
046	For MH/MR programs, percent dealing adequately with problems of the children	Mildly retarded	81.8	91.7
		Moderately retarded	72.7	91.7
		Severely retarded	72.7	83.3
047	Programs reporting emotionally disturbed children		56.3	54.4
048	Number of emotionally disturbed children (of programs reporting emotionally disturbed children)	One	32.1	42.6
		2-10	58.0	49.9
		over 10	9.9	7.5
049	For programs reporting emotionally disturbed children, percent dealing adequately with the problems		22.2	41.2
050	Programs reporting children with learning disabilities		51.4	49.6
051	Number of learning disabled children (of programs reporting learning disabled children)	One	45.8	33.9
		2-10	40.3	43.5
		over 10	13.9	22.6
052	For programs reporting learning disabled children, percent dealing adequately with learning disabilities		26.0	64.5
053	Programs reporting children with disabilities other than those named above		62.7	74.4
053	For programs reporting additional problems, number of additional types of problems reported	One	52.8	43.0
		Two	32.6	34.4
		Three	10.1	9.7
		Four	4.5	12.9

TABLE 12 (Cont'd)

HSCC ITEM	CONTENT	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
056	Total number of children with special needs (for all programs)	None	12.7	13.6
		1-5	41.5	35.2
		6-10	16.2	21.6
		11-15	10.6	10.4
		16-20	4.9	3.2
		21-30	4.2	6.4
		over 30	8.5	9.6
		No response	1.4	0.0

III. INTERNAL PLANNING OF HEALTH COMPONENT (057-065)

HSCC ITEM	CONTENT	PRE PERCENTAGE	POST PERCENTAGE
057	One or more persons at site responsible for direction and implementation of health component	85.2	97.6
058	Percent of <u>all</u> programs having at least one person responsible for health component	85.2	97.6
059	Of people at site responsible for health component, percent of <u>all</u> programs for which one person is directly in charge	77.5	92.0
060	Of <u>all</u> programs, percent in which Advocate is directly responsible for health components	19.7	34.4
060	Of <u>all</u> programs, percent in which Advocate is among those responsible for health component including being person directly responsible	46.5	81.6
061	Of <u>all</u> programs, percent having a person schedule health services for any of the children	79.6	87.2
062	Of <u>all</u> programs, percent informing parents when program schedules health services for children	79.6	87.2
063	Of <u>all</u> programs, percent informing parents of outcome of health services performed by program	78.2	86.4
064	Of <u>all</u> programs, percent in which parents inform program of health services they have scheduled for their children	84.5	89.6
065	Of <u>all</u> programs, percent in which parents inform program of outcome of health services they provide for their children	80.3	86.4

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

IV. HEALTH SERVICES SCREENING SCALE (066)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
066	Percent of programs performing or arranging to have performed screening tests to detect possible health problems		73.9	86.4
	Percent of programs for which particular tests are appropriate	Lead	70.4	84.0
		G6Pd	70.4	84.0
		Sickle	70.4	84.0
		Vdrl	4.9	4.8
	Height and Weight Screening			
	(1) Is the test provided?		62.0	75.2
	(2) Who provides the test? (for those providing)	Parents	5.7	12.8
		Program	81.8	55.3
		Both	12.5	31.9
	(3) For those providing, program has parental consent		70.5	61.7
	(4) For those programs performing procedure on-site, procedure is performed adequately		12.7	25.9
	(5) For those programs using off-site facility, procedure is performed adequately		84.0	95.8
	Vision Screening			
	(1) Is the test provided?		59.9	80.0
	(2) Who provides the test?(of those providing)	Parents	3.5	6.4
		Program	78.8	48.0
		Both	17.6	25.6
	(3) For those providing, program has parental consent		85.9	86.0
	(4) For those programs providing procedure in-site, procedure performed adequately		72.7	95.6
	(5) For those programs using off-site facility, procedure is performed adequately		93.1	100.0
	Hearing Screening			
	(1) Is the test provided?		54.2	63.2
	(2) Who provides the test?(for those providing)	Parents	2.1	7.6
		Program	43.7	55.7
		Both	8.5	36.7
	(3) For those providing, program has parental consent		80.5	86.1
	(4) For those programs providing procedure on-site, procedure is performed adequately		57.1	82.9
	(5) For those programs using off-site facility, procedure is performed adequately		88.9	100.0

Table 12

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
066 (con't)	Anemia Screening			
	(1) Is the test provided?		44.4	48.8
	(2) Who provides the test? (for those providing)	Parents	6.3	16.4
		Program	82.5	44.3
		Both	11.1	39.3
	(3) For those providing, program has parental consent		82.5	
	(4) For programs providing test, facility performs test adequately		93.3	98.0
	Lead			
	(1) Is the test provided?		31.7	46.4
	(2) Who provides the test? (for those providing)	Parents	8.9	13.8
		Program	77.8	48.3
		Both	13.3	37.9
	(3) For those providing, program has parental consent?		80.4	82.8
	(4) For programs providing test, facility performs test adequately		97.6	98.0
	G6Pd Screening			
	(1) Is the test provided?		8.5	20.0
	(2) Who provides the test?	Parents	0.0	24.0
		Program	83.3	20.0
		Both	16.7	56.0
	(3) If program provides, have parental consent		91.7	72.0
	(4) For programs providing test, facility performs test adequately		100.0	100.0
	Sickle Screening			
	(1) Is the test provided?		42.3	43.2
	(2) Who provides the test?	Parents	4.5	24.1
		Program	77.3	42.6
		Both	18.2	33.3
	(3) For those providing, program has parental consent		88.6	74.1
	(4) For programs providing test, facility performs test adequately		100.0	97.6

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
066 (Cont'd)	VDRL Screening			
	(1) Is the test provided?		0.0	1.6
	(2) Who provides the test?	Parents	---	0.0
		Program	---	0.0
		Both	---	100.0
	(3) For those providing, program has parental consent		---	100.0
	(4) For programs providing test, facility performs test adequately		---	100.0
	Urine Screening			
	(1) Is the test provided?		41.5	52.8
	(2) Who provides the test?	Parents	6.8	21.2
		Program	83.1	43.9
		Both	10.2	34.8
	(3) For those providing, program has parental consent		83.1	77.8
	(4) For programs providing test, facility performs test adequately		94.7	96.2
	Developmental & School Performance Screening			
	(1) Is the test provided?		35.2	54.4
	(2) Who provides the test?	Parents	0.0	2.9
		Program	88.0	64.7
		Both	12.0	32.4
	(3) For those providing, program has parental consent		68.0	58.8
	(4) For programs providing test on-site, procedure is performed adequately		68.4	75.4
	(5) For test performed off-site, facility performs test adequately		93.8	88.9
	Number of additional screening tests provided by programs other than those listed above (for all programs)	None	84.5	84.8
		One	14.1	13.6
		Two	.7	1.6
		Three	.7	0.0
		over three	0.0	0.0

Table 12

TABLE 12 (Cont'd)

V. HEALTH SERVICES -- MEDICAL EVALUATION AND TREATMENT (072-079)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
072	Percent of programs providing any form of treatment or medical evaluation		89.4	98.4
	DPT or DP Immunization			
	(1) Is the service provided?		59.2	78.4
	(2) Who arranges the service?	Parents	28.6	56.1
		Program	46.4	7.1
		Both	25.4	36.7
	(3) For those programs arranging, program has parental consent form		69.0	40.8
	(4) For those programs arranging service, facility provides adequate service		93.3	95.3
	Oral Polio Immunization			
	(1) Is the service provided?		58.5	77.6
	(2) Who arranges the services?	Parents	28.9	55.7
		Program	44.6	7.2
		Both	26.5	37.1
	(3) For those programs arranging service, program has consent form		68.7	41.2
	(4) For programs arranging service, facility provides service adequately		93.2	95.3
	Rubeola Immunization			
	(1) Is the service provided?		57.7	76.8
	(2) Who arranges the service?	Parents	30.5	55.2
		Program	45.1	7.3
		Both	24.4	37.5
	(3) For programs arranging service, program has consent form		67.1	41.7
	(4) For programs arranging service, facility provides service adequately		94.6	95.3

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
072 (cont'd)	Rubella Immunization			
	(1) Is the service provided?		57.0	73.6
	(2) Who arranges the service?	Parents	29.6	54.3
		Program	46.9	7.6
		Both	23.5	38.0
	(3) For programs arranging service, program has consent form		69.1	42.4
	(4) For programs arranging service, facility provides service adequately		93.0	95.2
	Routine Health Supervision			
	(1) Is the service provided?		41.5	65.6
	(2) Who arranges the service?	Parents	27.1	51.2
		Program	47.5	8.5
		Both	25.4	40.2
	(3) For programs arranging service, program has consent form		73.3	43.9
	(4) For those programs arranging service, facility provides service adequately		72.9	95.0
	Medical Evaluation for Diagnosis of a Suspected Health Problem			
	(1) Is the service provided?		58.5	77.6
	(2) Who arranges the service?	Parents	30.1	50.5
		Program	45.8	6.2
		Both	24.1	43.3
	(3) For programs arranging service, program has consent form		67.5	45.4
	(4) For those programs arranging service, facility provides service adequately		94.8	95.8
	Treatment of a Health Problem by a Health Professional			
	(1) Is the service provided?		45.1	73.6
	(2) Who arranges the service?	Parents	48.4	58.7
		Program	31.3	3.3
		Both	20.3	38.0
	(3) For programs arranging service, program has consent form		51.6	38.0
	(4) For programs arranging service, facility provides service adequately		96.7	94.7

Table 12

147

148

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
072 (cont'd)	Routine Dental Supervision			
	(1) Is the service provided?		56.7	75.2
	(2) Who arranges the service?	Parents	11.1	13.8
		Program	73.6	51.1
		Both	15.3	35.1
	(3) For programs arranging service, program has consent form		86.1	77.7
	(4) For those arranging service, facility provides adequately		85.9	90.1
	Dental Evaluation of Suspected Problems			
	(1) Is the service provided?		52.8	76.0
	(2) Who arranges the service?	Parents	14.7	50.5
		Program	62.7	15.8
		Both	22.7	33.7
	(3) For programs arranging service, program has consent form		80.3	45.3
	(4) For those arranging service, facility provides service adequately		82.8	91.5
	Dental Treatment			
	(1) Is the service provided?		43.0	69.6
	(2) Who arranges the service?	Parents	34.4	55.2
		Program	47.5	11.5
		Both	18.0	33.3
	(3) For programs arranging service, program has consent form		62.9	40.2
	(4) For programs arranging, facility provides service adequately		85.0	92.3
	Emergency Medical Care			
	(1) Is the service provided?		88.0	98.4
	(2) Who arranges the service?	Parents	2.4	0.0
		Program	64.8	42.3
		Both	32.8	57.7
	(3) For programs arranging service, program has consent form		90.4	99.2
	(4) For programs arranging service, facility provides service adequately		60.0	87.8

Table 12

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
072 (cont'd)	Number of medical services arranged by parents and/or program other than those listed above.	None	92.3	88.8
		One	7.7	10.4
		More than two	0.0	.8
077	When children are provided health services, are they always, sometimes, or never out of the program site? (of those programs providing at least one health service)	Yes, always	22.1	12.8
		Yes, sometimes	60.0	85.6
		Never	17.9	1.6
		Unknown	0.0	0.0
078	Of programs taking children out of program site for health services, who accompanies child to health services?	Mostly the parents	53.8	69.1
		Mostly child care staff or volunteer	44.4	28.5
		Someone other than parents, staff or volunteer	1.7	2.4
079	Of programs providing at least one health service, does program provide transportation to enable children to keep professional appointments?	Yes, always	15.5	7.2
		Yes, sometimes	37.3	43.2
		Never	46.5	48.8
		Unknown	.7	.8

Table 12

VI. HEALTH RECORDS SCALE (082-092)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
082	Program uses health worksheet like modified Head Start Form		22.5	56.8
083	Individual records of dental services maintained for each child in program		42.3	46.4
084	Individual records of medical services maintained for each child in program		84.5	95.2
085	Health information concerning services provided to children are updated as children receive services.	Yes, always	52.5	76.0
		Yes, sometimes	29.8	20.8
		Never	9.2	2.4
		Unknown	8.5	.8

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
086	Frequency with which all of the children's medical records are reviewed	Quarterly	25.0	49.2
		Semi-annually	17.9	14.5
		Annually	26.4	26.6
		Never	13.6	4.0
		Unknown	17.1	5.6
088	Frequency with which invididual health records are transferred to child's new school as child leaves program	Yes, always	45.8	43.2
		Yes, sometimes	19.7	27.2
		Never	26.1	27.2
		Unknown	8.5	2.4
089	Of programs transferring records, frequency with which parental consent is obtained for transferring records	Yes, always	66.7	69.8
		Yes, sometimes	21.6	22.2
		Never	7.8	6.3
		Unknown	3.9	1.6
090	Someone on program staff assures children's appointments for health services are kept.		69.7	77.6
091	Health record date of each child reviewed with staff at least once during program year.		47.9	69.6
092	Caregivers asked to express in writing their concerns about a child to the health care provider before child receives health assessment.		33.8	46.4

VII. HEALTH POLICIES AND PROCEDURES (093-127)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
093	Developmental assessment is performed when child enters program	Always	26.8	40.0
		Sometimes	20.4	17.6
		Never	45.8	41.6
		Unknown	7.0	.8
094	Developmental assessment is performed on child at least every six months.	Always	20.4	37.6
		Sometimes	18.3	16.0
		Never	53.5	44.0
		Unknown	7.7	2.4

Table 12

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
095	Program has established policy for enrollment of children with health problems		71.8	88.0
097	Program has established policy for obtaining health information on each child that enters program		88.0	97.6
099	Program has available written policies and procedures for health care		36.6	80.8
	Policies Include:			
101[a]	description of daily health inspection		50.0	80.2
102[a]	procedure for management of sudden illness		90.4	94.1
103[a]	procedure for accident and injury management		90.4	98.0
104[a]	description of safety precautions to be followed by program staff		73.1	83.2
105[a]	description of appropriate health supervision and ongoing medical care including immunization		71.2	89.1
106[a]	procedure for follow-up of identified health problems		54.9	63.4
107[a]	Health problems for which follow-up procedures have been specified in policies (for programs having procedures for follow-up of identified health problems)	Growth Problem	40.0	15.4
		Vision Problem	57.1	30.8
		Hearing Problem	60.0	27.7
		Anemia Problem	57.1	18.5
		Lead Poisoning	51.4	20.0
		Sickle Cell	54.3	16.9
		G6Pd Deficiency	17.1	6.2
		VDRL--Positive	8.6	0.0
		Urine -- Abnormal	42.9	20.0
		TB Test--Positive	51.4	24.6
		Developmental/School	52.9	24.6
		Respiratory Infection	51.2	15.4
		Skin Infection	45.7	27.7
109	Number of other problems for which procedures are specified in health policies (of programs having written health policies)	None	86.5	97.0
		1-2	7.7	2.0
		3-4	1.9	0.0
		5-6	1.9	0.0
		7-8	0.0	0.0
		9-10	1.9	0.0
		more than 10	0.0	1.0

[a]Percents of those programs having written policies.

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
110	Written policies are discussed in staff orientation (of day care programs with written policies)		76.0	80.2
111	Health policies have been discussed with staff in past 12 months (of center day care programs with written policies)		80.0	96.0
112[b]	Written policies are used in self-evaluation of programs and staff members		52.9	62.4
113[c]	Health policies were reviewed and revised in past 12 months		70.0	86.1
114[c]	Health policies were discussed with parents in past 12 months		80.4	84.2
116[c]	Health policies were discussed with volunteers within past 12 months (programs with volunteers)		59.1	67.4
117	Medicine is administered at program site		59.9	60.8
118	Of those programs administering medicine, standing orders, instructions issued by physician or prescription label are required	Always	82.1	82.9
		Sometimes	8.3	7.9
		Never	7.1	9.2
		Unknown	2.4	0.0
119	Program is informed when child received medication at home	Always	27.0	15.2
		Sometimes	69.3	81.6
		Never	2.9	3.2
		Unknown	.7	0.0
120	Facility has in writing the name, address and phone number of a doctor or health resource to be called in case of emergency		87.3	97.6
121	Program has policy regarding child's attendance when he is sick		93.0	97.6

[b]Of programs with written policies
[c]Of programs with more than one year in operation which have written health policies

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
123	Policy regarding attendance during illness is presented to parents at the time of child's enrollment (of programs having policy)	Always	79.5	86.2
		Sometimes	12.9	9.8
		Never	6.8	2.4
		Unknown	.8	1.6
124	Policy includes arrangements for transportation of sick or injured child to an emergency facility		93.0	100.0
125	Policy for transportation of sick or injured child includes presence of adult other than driver (of programs having policy)		84.2	93.6
127	Provision for alternative coverage of responsibilities for supervision of other children in program when adult care giver accompanies child to emergency facility.		92.5	96.0

VIII. HEALTH EDUCATION SCALE (128-143)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
128	Member of staff meet with teachers to plan health instruction		57.7	76.0
129	Of those holding meetings, frequency of meetings	Weekly	23.2	14.6
		Monthly	33.3	50.6
		Quarterly	16.0	15.7
		Semi-annually	16.0	7.9
		Annually	10.1	10.1
		Unknown	1.4	1.1
		Never	0.0	0.0
130	Health procedures are discussed in child care setting prior to delivery of health service to children	Always	56.3	70.4
		Sometimes	23.9	21.6
		Never	16.9	5.6
		Unknown	2.8	2.4
132	Public service personnel, (e.g., policemen, firemen, public health personnel) participate in safety and sanitation instruction of staff and/or children		69.7	79.2

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
133	Public service groups participating (of all programs)	Police	47.2	52.8
		Fire	59.9	75.2
		Public Health	8.5	16.8
134	Parent-staff conferences and meetings are held		94.4	97.6
135	Of programs holding meetings, medical, dental and nutrition information is included in agenda of meetings		88.9	92.7
136	Frequency with which health issues are discussed at parent-staff meetings	Weekly	6.6	4.6
		Monthly	17.9	31.5
		Quarterly	28.3	19.4
		Semi-annually	22.6	24.1
		Annually	13.2	13.9
		Unknown	8.5	4.6
		Never	2.8	1.9
137	Local health care resources for comprehensive family health services are available to families served by program		81.7	92.0
138	Of programs in areas in which local health care resources for comprehensive family health services available, program informs parents of any available services		76.8	97.4
140	Health professionals from community involved in providing health instruction to children		24.6	31.2
141	Frequency with which health professionals come to program site (of programs employing health professionals)	Weekly	9.4	2.9
		Monthly	25.0	8.8
		Quarterly	28.1	32.4
		Semi-annually	6.3	26.5
		Annually	25.0	23.5
		Unknown	0.0	2.9
		Never	6.3	2.9
142	Program holds in-service staff conferences to discuss health matters		71.1	90.4

Table 12

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
143	Frequency with which health issues are discussed at in-service conferences (of programs holding in-service conferences)	Weekly	11.9	6.7
		Monthly	34.5	37.1
		Quarterly	25.0	23.8
		Semi-annually	13.1	17.1
		Annually	13.1	11.4
		Unknown	2.4	3.8
		Never	0.0	0.0

Table 12

IX. STAFF HEALTH (144-160)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
144	Employees are screened for Tuberculosis annually		83.8	95.2
145	Program has food handlers		92.3	94.4
146	For Philadelphia centers with food handlers, food handlers have food handlers certificate		81.6	88.0
147	For non-Philadelphia centers with food handlers, kitchen staff have physician-issued note certifying health and competency to serve as food handlers	All Staff	60.6	46.2
		Some Staff	0.0	7.7
		No Staff	18.2	42.3
		Unknown	21.2	3.8
150	Program requires physician's statement attesting to health and competency of caregiver prior to hiring		88.7	92.0
152	Items covered by physician's statement attesting to health and competency of caregiver (of programs requiring physician's statement) are:			
	Presence versus absence of general infection		67.6	60.3
	Presence versus absence of skin or respiratory infection		64.7	37.9
	Presence versus absence of high blood pressure		45.6	37.9
	Level of mental stability		47.1	44.8
	Level of exertion tolerance		25.4	27.6
153	Of programs requiring physician's statement, statement is renewed annually		49.2	53.0

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
154	Check is done to see that no staff member has prior police record, arraignment, or conviction for child abuse, neglect, sexual abuse or any offense which implies behavior detrimental to child care competency		37.3	52.0
155	Program has policy for coverage for sick caregiver and food service personnel		93.0	96.8
156	Of programs with policy, it is satisfactory to parents and staff		94.7	93.4
157	Of programs with policy, policy includes paid sick leave		93.2	91.7
158	Of programs with policy, policy includes staff coverage by regular substitutes		79.5	90.7
159	Handwashing after toileting or handling excrement is consistently performed		92.3	96.8
160	Health habits appraised as part of on-going staff evaluation	Always	41.5	65.5
		Sometimes	32.4	22.4
		Never	19.0	5.6
		Unknown	7.0	6.4

X. DENTAL CARE (162-165)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
162	Program in area with floridated water, gives no fluoride supplement		96.2	90.6
	Program in area without flouridated water, gives flouride supplement		36.1	37.9
163	Tooth brushing is taught to children		74.6	80.0

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENT	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
164	Program has children over 12 months of age practice toothbrushing daily	Always	42.3	52.8
		Sometimes	22.5	20.8
		Never	35.2	25.6
		Unknown	0.0	.8
165	Program has local dentists and/or dental hygienists participate in a dental education program for staff and children		35.9	56.0

XI. EVACUATION, EMERGENCY, AND DISASTER PLANS (166-173)

HSCC ITEM	CONTENTS	PRE PERCENTAGE	POST PERCENTAGE
166	Program has plans for emergencies such as accidents, injuries, fire and flood	87.3	96.0
167	Of those with plans, plans are approved by someone who knows about plans	80.8	82.4
169	Plans for emergencies are conspicuously posted	32.3	44.2
170	Program has had a disaster or fire drill within past month	59.9	73.6
171	Program has had disaster or fire drill within past 3 months (excluding those having fire or disaster drill within past month)	14.1	14.4
172	Program has disaster or fire drill log book	63.4	81.6
173	Log book is shown (of those saying they have log book)	38.7	71.6

XII. FIRST AID (148, 149, 174-176)

HSCC ITEM	CONTENTS	PRE PERCENTAGE	POST PERCENTAGE
148	At least one staff member is trained in first aid	68.3	94.4
149	Of programs with volunteers, at least one volunteer is trained in first aid	29.3	44.8

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	PRE PERCENTAGE	POST PERCENTAGE
174	First aid equipment is available in each child area	48.9	44.0
175	First aid equipment is kept in at least one area of the building (for those programs not having equipment in each child area)	97.4	100.0
176	Some member of the staff has inspected the first aid supplies within the past 3 months (verified)	90.1 (96.1)	96.0 (95.0)

XIII. ENVIRONMENTAL QUALITY AND SAFETY (179-232, 268, 269)

HSCC ITEM	CONTENTS	PRE PERCENTAGE	POST PERCENTAGE
179	Premises are rodent and vermin free	64.8	74.4
180	Premises has no open drainage ditches, wells or holes on the property into which children could fall	93.0	88.8
181	Premises has adequate drainage so there are no stagnant pools	89.4	90.4
182	Garbage and trash is stored in covered containers	84.5	86.4
183	Trash is removed frequently	95.8	97.6
184	Program site has outside stairs	50.0	56.8
185	Of programs with outside stairs, stairs have safety gates	23.6	15.5
186	If program has outside steps, there are ramps where steps are steep or hazardous	63.9	90.1
187	Program site has inside staircases that children might use	76.1	77.6
188	Of programs with inside staircases, all inside staircases have right hand descending handrails	77.1	84.7
189	All openable windows and doors are screened	47.2	56.8
190	All major outside doors are equipped with panic hardware (center day care programs)	66.9	72.4

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	PRE PERCENTAGE	POST PERCENTAGE
191	Program has or anticipates having children in program confined to wheelchairs	9.2	8.8
192	Of programs having or anticipate having children in wheelchairs, doors are wide enough to accomodate wheelchairs	92.3	90.9
193	Rooms are adequately ventilated	88.7	92.0
194	Temperature in all rooms is kept between 65° and 78°	83.8	81.6
195	All rooms are adequately lighted	93.7	97.6
196	Floor heaters are not used	90.1	86.4
197	Heating elements including hot water pipes are insulated so that children can not be burned	78.9	88.8
198	Floor space allows for active play	95.8	98.4
199	Floor space provides areas for quiet rest	96.5	97.6
200	Arrangement of floor space provides for individual activities	99.3	99.2
201	Furniture, equipment and toys are appropriate to the ages of the children	97.9	100.0
202	Furniture, equipment, and toys are sturdily constructed, easily cleaned and do not have sharp or splintered edges.	96.5	100.0
203	Program site has carpet	62.7	66.4
204	If program site has carpets, none are made of wool	53.9	67.5
205	If program site has carpets, they are easy to clean	91.0	96.4
206	Fabrics of drapes, blankets, etc. are fire resistive	31.9	27.2
207	Walls have been checked to insure there is no lead based paint	72.5	84.0
208	Plastic bags and small objects are kept out of the reach of young children	91.5	96.8
209	All accessible electrical outlets are fitted with plastic plugs or other suitable devises to prevent tampering by children	36.6	54.4

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
210	Electrical cords are well insulated		97.2	99.2
211	Electrical cords are inaccessible to children		90.1	91.2
212	Ratio of flush toilets to children	Arithmetic Mean Standard Deviation		
213	Potty chairs are not used		81.7	79.2
214	Hot water temperature does not exceed 120° where accessible to children		64.8	70.4
215	Program has laundry facilities on the premises		26.1	25.6
216	For programs with laundry facilities, they are separate from food preparation areas and toilet rooms.		91.9	87.9
217	For programs with children under 5 years of age, there are low bathroom fixtures to accomodate the children.		64.4	81.2
218	For programs with children under 5 years of age,not having low bathroom fixtures, program provides safe step stools so that children can easily use standard sized toilets and lavatories		51.1	72.7
219	Handwashing facilities are in or immediately adjacant to child care areas		89.4	92.0
220	Where no handwashing facilities are in or immediately adjacant to child care areas, program uses portable wash basins for routine handwashing.		50.0	88.9
221	Program has specific area where clothes or diapers are changed		55.6	73.6
222	Of programs with clothes/diaper changing area, there are handwashing facilities close to the area		100.0	97.8
223	Program has plan for regular cleaning of the facility Of those programs having plan, plan is adequate		99.3 93.6	96.8 98.4

Table 12

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
224	Program has necessary cleaning equipment		97.2	98.4
226	For those programs reporting location of cleaning equipment relative to the children, cleaning equipment is reported to be out of the reach of the children		81.3	93.6
227	Frequency with which equipment used in food preparation is cleaned after use is:	Always	95.8	99.2
		Sometimes	2.1	0.0
		Never	2.1	.8
		Unknown	0.0	0.0
228	All toxic cleaning products are kept out of the reach of children		93.7	97.6
229	Program performs safety and environmental quality surveys on the premises		66.2	87.2
230	For programs performing surveys, frequency of surveys is:	Weekly	71.3	47.7
		Monthly	5.3	29.4
		Quarterly	3.2	8.3
		Semi-annually	3.2	6.4
		Annually	6.4	1.8
		Other	10.7	6.4
231	Program keeps log of results of the safety and environmental quality checks		12.0	28.8
232	For those programs keeping safety and environmental quality check logs, contents of log includes:	Date of survey	58.3	88.5
		List of hazards noted	58.3	100.0
		Notation of hazards corrected	58.3	76.9
		Name of person doing survey	50.0	73.1
268	Facility was inspected for safety and sanitation by the Health Department or another appropriate agency within the past year.		82.4	84.0
269	Inspection certificate or inspection results are shown (date is recorded of those reporting having facility inspected)		59.0	78.1

Table 12

XIV. NUTRITION (233-259)

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
233	Meals or snacks are served by the program		98.6	100.0
234	Parents are consulted to coordinate food planning in program with home meal patterns	Always	24.3	13.6
		Sometimes	31.4	28.8
		Never	43.6	55.2
		Unknown	.7	2.4
235	Program has menus		86.4	89.6
236	For programs reporting having menus, a sample menu is given		66.7	62.5
237	For programs reporting having menus, the frequency with which written menus are posted in advance of the meals are:	Always	78.0	85.7
		Sometimes	12.2	9.8
		Never	9.8	4.5
		Unknown	0.0	0.0
239	When a child is enrolled, information is gathered concerning eating habits	Always	83.7	96.0
		Sometimes	5.7	2.4
		Never	10.6	1.6
		Unknown	0.0	0.0
240	For programs gathering information concerning eating habits when a child is enrolled, information is gathered concerning usual feeding schedule	Always	42.3	54.0
		Sometimes	3.8	6.5
		Never	53.8	39.5
		Unknown	0.0	0.0
241	For programs gathering information concerning eating habits when a child is enrolled, information is gathered concerning use of vitamins or mineral supplements.	Always	30.2	46.8
		Sometimes	8.5	8.9
		Never	59.7	41.9
		Unknown	1.6	2.4
242	For programs gathering information concerning eating habits when a child is enrolled, information is gathered concerning home feeding practices	Always	48.8	66.9
		Sometimes	11.6	6.5
		Never	37.2	25.0
		Unknown	2.3	1.6
243	For programs gathering information concerning eating habits when a child is enrolled, information is gathered concerning formula and food preferences	Always	76.2	83.9
		Sometimes	8.5	6.5
		Never	14.6	8.9
		Unknown	.8	.8

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
244	When a child is enrolled, information is gathered concerning formula and food sensitivities or allergies.	Always	92.3	95.2
		Sometimes	2.3	2.4
		Never	4.6	2.4
		Unknown	.8	0.0
245	Program has adequate supplies of food and formula for individual children available	Always	95.0	96.0
		Sometimes	2.1	4.0
		Never	2.1	0.0
		Unknown	.7	0.0
246[a]	Program provides finger foods for children 6-12 months old		100.0	100.0
247[a]	Infants are held for feeding	Always	50.0	80.0
		Sometimes	50.0	20.0
		Never	0.0	0.0
		Unknown	0.0	0.0
248[a]	Program does not permit bottle propping		85.7	80.0
249[a]	Program provides equipment to include children in group feeding		100.0	100.0
250[a]	For those programs providing group feeding equipment, program generally practices group feeding		100.0	100.0
251[a]	Program does not permit force feeding		85.7	70.0
252[a]	Menus are planned to include feeding at least every four hours		85.7	90.0
253	Program provides snacks in mid-morning or mid-afternoon	Always	96.8	96.0
		Sometimes	3.5	3.2
		Never	.7	.8
		Unknown	0.0	0.0
254	For programs providing snacks they include representatives of the:	Meat Group	29.3	49.2
		Milk Group	78.6	67.7
		Cereal Group	98.6	91.9
		Fruit and Vegetable Group	96.4	94.4

[a]Items apply only to programs with children under 18 months of age, N=14 pre sites, N=10 post sites

Table 12

TABLE 12 (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
255	For programs providing snacks, they are noted on a menu	Always	57.0	72.4
		Sometimes	3.1	6.0
		Never	39.8	21.6
		Unknown	0.0	0.0
256[b]	Program is equipped to feed children in groups		100.0	100.0
257[b]	Program does not permit force feeding		88.0	84.8
258[b]	Program does not use food as punishment or reward		73.9	72.0
259[b]	Staff eats with the children	Always	81.0	84.8
		Sometimes	12.7	14.4
		Never	6.3	.8
		Unknown	0.0	0.0

XV. ROUTINE TRANSPORTATION (260-267)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
260	Program transports children	Always	24.6	18.4
		Sometimes	68.3	76.0
		Never	7.0	5.6
		Unknown	0.0	0.0
261	For programs transporting children, vehicles meet state inspection standards		90.2	98.3
262	For programs transporting children, vehicles for transporting children are insured for that purpose		81.1	94.1
263	For programs transporting children, suitable restraints or seat belts are provided for each child		21.4	26.3

[b]Items apply only to programs with children 18 months of age or over, N=142 pre sites, N=125 post sites

TABLE 12--SUMMARY OF RESPONSES TO HSCC ITEMS--PRE VERSUS POST (Cont'd)

HSCC ITEM	CONTENTS	CATEGORY	PRE PERCENTAGE	POST PERCENTAGE
264	For programs transporting children who provide restraints or seat belts for each child, belts are used when vehicle is in motion	Always	72.7	83.9
		Sometimes	12.1	9.7
		Never	12.1	6.5
		Unknown	3.0	0.0
265	For programs transporting children, all drivers are licensed		100.0	100.0
266	For programs transporting children, all drivers are insured for passenger liability		87.1	96.6
267	For programs transporting children, attendant is present for supervision in addition to the driver.	Always	84.8	91.5
		Sometimes	13.6	6.8
		Never	1.5	1.7
		Unknown	0.0	0.0

Table 12

Table 13

Score	CYCLE A-Pre	B-Pre	C-Pre	D-Pre	G-Pre	E-Pre[1]$_1$	F-Pre[1]$_1$	E-Pre[2]$_2$	F-Pre[2]$_2$	E-Pre Extra[3]
Number of Sites[4]	20	18	24	21	28	11	8	11	8	12
External Planning Scale Score	35.00 (20.52)	51.39 (30.28)	20.83 (20.41)	32.14 (21.13)	33.04 (20.47)	38.64 (36.00)	34.38 (18.60)	54.55 (26.97)	56.25 (17.68)	45.83 (27.87)
Special Needs Scale Score (Of programs having special needs children)	39.59 (34.02)	30.78 (31.45)	21.17 (27.41)	48.00 (39.23)	20.58 (29.85)	27.64 (32.42)	35.50 (33.65)	47.40 (38.50)	39.86 (23.20)	23.50 (29.05)
Number of Types of Special Needs (of all programs)	3.15 (1.98)	4.61 (1.97)	3.00 (2.50)	2.95 (1.96)	3.36 (2.63)	4.82 (2.23)	4.25 (1.28)	4.45 (2.30)	4.25 (2.38)	4.08 (1.89)
Number of Incidences of Special Needs (of programs having special needs children)	14.82 (25.81)	29.00 (32.80)	13.22 (19.02)	8.11 (8.24)	22.35 (51.37)	22.45 (26.50)	16.00 (16.98)	28.40 (36.45)	15.14 (16.25)	27.58 (60.26)
Number of Children With Special Needs (of programs having special needs children)	8.82 (9.02)	18.44 (23.50)	10.50 (17.35)	7.47 (8.39)	14.23 (34.24)	15.18 (11.50)	8.63 (4.41)	11.90 (14.35)	8.14 (5.31)	18.92 (33.69)
Number of Programs with Special Needs Children	17	18	18	19	26	11	8	10	7	12
Internal Planning Scale Score	76.40 (23.71)	79.28 (20.94)	82.13 (22.38)	86.43 (20.90)	75.93 (26.48)	80.45 (21.50)	85.63 (13.43)	92.09 (13.55)	89.13 (15.01)	84.58 (24.63)
Advocate Named as Directly Responsible for Planning Health Component	10%	44%	13%	14%	25%	9%	25%	9%	62%	8%
Advocate Among Those Listed as Responsible for Planning Health Component (including those named as directly responsible)	65%	50%	26%	71%	36%	36%	25%	27%	100%	62%
Percent of Programs Furnishing Health Services-Screening	90%	78%	61%	100%	57%	64%	75%	100%	100%	75%
Health Services Screening Scale Score (of all programs)	40.30 (34.26)	37.61 (31.67)	15.67 (19.96)	45.52 (33.00)	24.96 (29.74)	34.00 (36.94)	34.38 (30.14)	53.00 (31.34)	36.88 (28.58)	42.67 (32.91)
Health Services Screening Consent Subscore (of programs providing screening)	5.56 (23.57)	4.07 (15.23)	28.87 (43.83)	28.53 (40.67)	48.81 (42.38)	10.71 (28.35)	0.00 (0.00)	48.91 (46.79)	0.00 (0.00)	56.22 (44.63)

Score	A-Pre	B-Pre	C-Pre	D-Pre	G-Pre	E-Pre$_1$[1]	F-Pre$_1$[1]	E-Pre$_2$[2]	F-Pre$_2$[2]	E-Pre Extra[3]
Evacuation, Emergency and Disaster Plan Scale Score	50.50 (28.56)	52.78 (24.45)	44.58 (26.54)	46.67 (19.32)	41.79 (22.62)	51.82 (19.91)	40.00 (32.07)	54.55 (11.28)	40.00 (30.24)	55.00 (26.80)
First Aid Scale Score	62.25 (34.89)	63.94 (31.80)	44.52 (35.00)	48.19 (35.77)	60.93 (35.95)	50.18 (31.17)	40.12 (29.14)	37.18 (32.95)	41.25 (38.74)	36.64 (36.56)
Percent Trained in First Aid of Those Required (may exceed 100% if more people trained than required.)	80.80 (79.12)	86.44 (80.87)	61.61 (105.23)	59.29 (89.11)	122.54 (129.62)	59.55 (72.11)	33.75 (49.18)	38.18 (64.56)	51.63 (76.98)	39.36 (59.87)
First Aid Equipment Subscale Score	78.75 (23.33)	76.39 (24.96)	76.09 (23.21)	69.05 (24.88)	71.43 (23.29)	65.91 (34.05)	68.75 (29.12)	68.18 (25.23)	59.38 (29.69)	59.09 (35.83)
Environmental Quality and Safety Scale Score	68.45 (10.72)	67.78 (10.67)	73.00 (11.07)	77.05 (6.77)	71.64 (11.87)	68.45 (9.73)	67.00 (9.47)	67.45 (10.26)	74.38 (7.13)	72.08 (9.05)
Nutrition Scale Score	57.75 (20.80)	63.50 (16.15)	54.91 (16.76)	62.67 (19.80)	68.00 (12.36)	70.45 (15.44)	63.00 (13.13)	70.18 (6.63)	59.00 (15.69)	63.92 (17.59)
Menu Subscore	60.15 (31.79)	60.72 (33.38)	39.58 (38.14)	65.67 (30.77)	64.75 (26.64)	66.82 (29.85)	62.63 (33.10)	71.45 (9.99)	71.00 (33.01)	72.42 (27.79)
Percent of Programs Providing Routine Transportation	100%	94%	83%	95%	11%	91%	100%	91%	100%	100%
Routine Transportation Scale Score (of programs providing routine transportation)	70.35 (5.66)	76.24 (18.87)	57.00 (20.53)	67.80 (24.76)	71.80 (17.70)	69.80 (15.73)	71.25 (20.20)	74.10 (20.01)	76.63 (7.76)	67.58 (10.71)
Medical Records Content Scale Score	22.40 (17.05)	22.06 (10.98)	32.46 (10.13)	27.10 (19.74)	38.79 (13.28)	25.91 (9.54)	34.00 (17.70)	40.73 (10.46)	50.38 (14.45)	44.33 (13.23)
Number of Programs for Which Medical Records Could Be Scored	20	18	24	20	28	11	8	11	8	12

NOTE: All Scale Scores have maximum of 100, indicating complete compliance.

1. These are E and F site scores one year preceding training.
2. These are E and F site scores just prior to training of sites originally evaluated one year prior to training.
3. These are E site scores of sites added to Cycle E at the time of training.
4. All available pretest data are included.

TABLE 13--SUMMARY HSCC PRE-TEST SCORES (Cont'd)

Score	A-Pre	B-Pre	C-Pre	D-Pre	G-Pre	E-Pre[1]	F-Pre[1]	E-Pre[2]	F-Pre[2]	E-Pre Extra[3]
Percent of Services Provided by Program (of programs providing screening)	43.56 (32.26)	45.14 (24.81)	18.60 (15.77)	42.48 (34.84)	40.81 (26.87)	53.43 (32.61)	43.83 (36.88)	51.73 (30.81)	36.88 (24.06)	56.89 (24.06)
Number of Programs Providing Screening	18	14	15	21	16	7	6	11	8	9
Percent of Programs Providing Medical Evaluation and Treatment	80%	72%	96%	95%	100%	73%	83%	91%	100%	100%
Medical Evaluation and Treatment Scale Score (of all programs)	50.05 (36.26)	50.72 (40.10)	31.21 (30.47)	55.52 (32.93)	51.68 (42.30)	44.64 (46.28)	55.75 (35.44)	65.36 (31.55)	60.25 (38.03)	69.58 (30.59)
Consent Subscore(of programs providing medical evaluation and treatment)	19.31 (28.43)	10.77 (21.74)	16.17 (31.44)	28.45 (35.34)	26.50 (33.66)	10.38 (29.34)	10.71 (28.87)	14.60 (26.76)	6.25 (17.67)	31.67 (38.87)
Escort Subscore(of programs providing medical evaluation and treatment)	66.63 (28.53)	84.46 (10.61)	62.35 (34.15)	54.95 (36.27)	66.11 (31.23)	79.12 (34.18)	87.86 (8.30)	61.70 (39.33)	87.25 (7.87)	66.83 (23.53)
Percent of Services Program Provides(of programs providing medical evaluation and treatment)	54.63 (31.60)	54.92 (34.33)	22.96 (27.58)	44.30 (29.37)	36.64 (35.88)	52.38 (36.99)	32.71 (32.01)	42.70 (25.13)	51.00 (35.45)	34.33 (30.35)
Number of Programs Providing Medical Evaluation and Treatment	16	13	23	20	28	8	7	10	8	12
Medical Records Process Scale Score	52.74 (20.55)	53.72 (19.36)	38.92 (23.70)	56.10 (24.46)	48.93 (25.83)	62.27 (19.29)	56.38 (22.60)	64.27 (13.24)	63.25 (12.64)	59.58 (24.02)
Health Policies and Procedures Scale Score	39.40 (16.46)	41.50 (20.04)	38.88 (19.46)	56.67 (21.04)	50.32 (24.59)	37.64 (18.68)	42.50 (16.40)	61.82 (16.12)	54.25 (22.44)	58.00 (18.67)
Health Education Scale Score	71.15 (19.39)	60.56 (23.65)	49.46 (28.14)	63.10 (16.36)	61.54 (22.36)	65.27 (21.68)	69.25 (17.56)	73.91 (17.90)	62.38 (17.84)	68.92 (22.73)
Staff Health Scale Score	59.95 (20.46)	63.72 (14.50)	63.83 (13.78)	69.62 (8.93)	62.93 (20.13)	68.37 (18.01)	69.13 (12.54)	73.45 (9.19)	74.63 (4.78)	73.50 (6.56)
Dental Care Scale Score	68.20 (26.46)	62.56 (24.25)	47.46 (27.14)	62.05 (26.68)	54.14 (32.80)	76.18 (23.99)	73.50 (14.02)	64.82 (32.02)	62.50 (18.90)	66.83 (24.63)

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TABLE 14

CONTRASTS AMONG PRE SCORES OF CYCLES A, B, C, D AND G ON THE HSCC

Score	F Test (df in parentheses)	Two-tailed p Value	Tukey Honestly Significant Difference $\alpha = .05$
External Planning Scale Score	4.81 (4,106)	.001	C<B
Special Needs Scale Score (of programs with special needs children)	2.68 (4,93)	.036	D<G
Number of Types of Special Needs (all program)	1.72 (4,106)	.150	-
Number of Incidences of Special Needs (of programs with Special Needs Children)	1.16 (4,93)	.333	-
Number of Children with Special Needs (of programs with Special Needs Children)	.74 (4,93)	.567	-
Internal Planning Scale Score	.79 (4,106)	.535	-
Advocate Named as Responsible for Health Component	2.45 (4,106)	.051	-
Advocate Among Those Listed as Planning the Health Component	3.54 (4,106)	.009	C<D
Percent of Programs Providing Health Services-Screening	4.76 (4,105)	.001	C<D, G<D
Health Services Screening Scale Score	3.82 (4,106)	.006	C<D
Consent Subscore	4.43 (4,79)	.003	A<G, B<G
Percent of Appropriate Tests Program Provides	2.29 (4,79)	.068	-

TABLE 14--CONTRASTS AMONG PRE SCORES ON THE HSCC (Cont'd)

Score	F Test (df in parentheses)	Two-tailed P Value	Tukey Honestly Significant Difference $\alpha = .05$
Percent of Programs Providing Medical Evaluation and Treatment	3.61 (4,106)	.008	B<C
Medical Evaluation and Treatment Scale Score (of all programs)	1.57 (4,106)	.187	-
Consent Subscore (of programs providing medical evaluation and treatment)	.98 (4,95)	.420	-
Escort Subscore (of programs providing medical evaluation and treatment)	1.88 (4,95)	.121	-
Percent of Services Program Provides (of programs providing medical evaluation and treatment)	3.49 (4,95)	.011	C<A, C<B
Medical Records Process Scale Score	1.91 (4,106)	.114	-
Health Policies and Procedures Scale Score	3.09 (4,106)	.019	C<D
Health Education Scale Score	2.64 (4,106)	.038	C<A
Staff Health Scale Score	.96 (4,106)	.435	-
Dental Care Scale Score	1.87 (4,106)	.122	-
Evaluation, Emergency and Disaster Plan Scale Score	.73 (4,106)	.574	-

Score	F Test (df in parentheses)	Two-tailed p Value	Tukey Honestly Significant Difference $\alpha = .05$
First Aid Scale Score	1.42 (4,105)	.233	-
Percent Trained in First Aid of Those Required	1.60 (4,105)	.180	-
First Aid Equipment Scubscale Score	.594(4,105)	.668	-
Environmental Quality and Safety Scale Score	2.57 (4,106)	.042	-
Nutrition Scale Score			
Menu Subscore	2.22 (4,106)	.072	-
Percent of Programs Providing Routine Transportation	1.21 (4,106)	.310	-
Routine Transportation Scale Score	2.91 (4,97)	.026	C<B
Medical Record Content Score	5.65 (4,105)	.001	A<G, B<G

Table 14

TABLE 15
SUMMARY ROLE FORM SUPERVISOR, PRE-TEST DATA
(Means with Standard Deviations Given in Parentheses)

Item	A-Pre	B-Pre	C-Pre	D-Pre	G-Pre	E-Pre[3]	F-Pre[3]	E-Pre2[4]	F-Pre2[4]	E-Pre Extra[5]
Number of Supervisors	19	17	19	14	15	11	7	6	7	8
Number of Applicable Items of 68 total[1]	65.68 (1.00)	65.76 (1.09)	64.89 (1.56)	66.07 (1.64)	64.87 (3.40)	65.36 (1.57)	66.86 (1.07)	65.83 (.75)	65.14 (4.49)	65.63 (1.06)
Percent of Activities in which Advocate is Involved	36.74 (21.97)	40.88 (18.18)	38.58 (23.14)	44.36 (18.66)	40.27 (23.46)	27.36 (9.51)	50.71 (21.98)	32.00 (15.43)	72.15 (25.15)	39.25 (12.62)
Reasons of Non-Involvement[2]										
Perceived as Inappropriate	3.42 (6.53)	2.70 (3.31)	5.53 (3.56)	5.36 (9.25)	10.07 (11.27)	3.55 (3.21)	.57 (1.51)	2.33 (1.97)	.71 (1.25)	5.13 (1.36)
Blocked Administratively	3.89 (9.10)	1.24 (3.53)	1.16 (1.92)	5.29 (8.44)	1.93 (4.42)	4.27 (5.98)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	.88 (1.25)
Not Planned For	32.79 (27.38)	27.76 (14.10)	17.58 (19.32)	21.57 (24.14)	31.60 (25.34)	16.45 (13.12)	37.29 (20.44)	15.33 (11.25)	36.00 (37.12)	32.25 (16.54)
Someone else Responsible for Activity	58.73 (29.25)	66.41 (18.36)	69.32 (24.35)	62.36 (26.74)	55.13 (25.06)	74.00 (16.48)	53.29 (22.95)	81.33 (13.09)	46.71 (37.57)	67.13 (21.26)
Other	1.21 (3.14)	1.82 (3.38)	6.32 (17.22)	5.29 (10.48)	1.20 (2.91)	1.73 (2.10)	8.86 (22.56)	1.00 (1.67)	16.71 (37.27)	3.38 (7.98)
How Advocate is Involved[2]										
Performing the Activity only	47.05 (26.65)	65.53 (17.54)	42.26 (21.64)	25.00 (22.45)	31.20 (26.97)	29.27 (10.12)	49.43 (23.31)	10.00 (11.21)	23.00 (25.16)	13.13 (12.72)
Advocating the Activity only	23.53 (14.18)	20.18 (10.99)	21.37 (19.32)	19.79 (15.83)	13.53 (8.89)	30.73 (25.44)	30.00 (13.94)	27.17 (13.15)	24.86 (7.69)	21.38 (9.21)
Mixture of Performing and Advocating	24.16 (19.60)	14.24 (14.56)	36.32 (29.13)	55.07 (22.66)	55.33 (25.14)	40.18 (25.36)	20.71 (14.43)	62.83 (19.87)	52.29 (25.33)	65.63 (15.15)
Total Performance- perform only plus more perform than advocate	56.63 (24.70)	73.12 (15.15)	57.79 (17.23)	61.79 (22.94)	67.40 (17.03)	41.18 (14.68)	57.57 (18.10)	41.67 (25.55)	50.29 (16.27)	51.75 (21.95)
Total advocacy- advicate only plus more advocate than perform	38.11 (22.52)	26.88 (15.15)	42.21 (17.22)	38.21 (22.94)	32.60 (17.03)	58.81 (14.68)	42.43 (18.10)	58.33 (25.55)	49.71 (16.27)	48.25 (21.95)
Who decides activity will be performed[2]										
Advocate decides	29.42 (24.77)	45.82 (28.56)	29.84 (22.94)	22.57 (29.63)	22.67 (33.36)	35.36 (16.78)	50.86 (36.46)	31.67 (21.53)	39.71 (36.74)	20.88 (25.08)
Supervisor decides	1.94 (3.26)	9.18 (17.30)	18.58 (18.02)	13.00 (19.96)	25.33 (30.37)	17.82 (15.95)	7.29 (11.53)	34.67 (23.57)	36.57 (38.24)	36.25 (38.45)
Mutual decision	63.32 (28.74)	45.06 (27.26)	51.32 (31.42)	64.43 (39.73)	52.07 (42.16)	46.82 (21.17)	41.71 (27.40)	33.67 (32.51)	23.86 (25.40)	43.12 (33.34)
Median Percent of time spent on Non-advocacy activities	50-75%	25-50%	50-75%	50-75%	50-75%	75-100%	75-100%	50-75%	75-100%	50-75%

Table 15

[1] These are the activities of the 68 activities in the Role Form which are applicable to a particular site, and on which scoring of the site is based.
[2] These are mean percentages of response to each alternative
[3] First pre test one year before training
[4] Second pretest on sites originally tested a year before training
[5] Sites added to Cycle E just before training

TABLE 16

CONTRASTS AMONG PRE SCORES OF CYCLES A, B, C, D, AND G ON THE ROLE FORM SUPERVISOR

Score	F Test (df in parentheses)	Two-tailed p value	Tukey Honestly Significant Difference, α = .05
Percent of Activities Appropriate for Site	1.36 (4,79)	.256	-
Percent of Activities in Which Advocate is Involved	.29 (4,79)	.886	-
Reasons of Noninvolvement			
Perceived as Inappropriate	2.54 (4,79)	.046	B<C
Blocked Administratively	1.41 (4,79)	.239	-
Lack of Planning	1.49 (4,79)	.213	-
Someone Else Responsible	.89 (4,79)	.476	-
Other	1.13 (4,79)	.351	-
How Advocate is Involved In Activity			
Perform Only	7.17 (4,79)	<.001	C<B, D<B, G<B
Advocate Only	1.07 (4,79)	.378	-
Mixture of Advocating and Performing	10.28 (4,79)	<.001	A<D, A<G, B<C, B<D, B<G
Total Performance	2.13 (4,79)	.081	-
Total Advocacy	1.68 (4,79)	.163	-
Who Decides Activity Will Be Performed			
Advocate Initiates	1.89 (4,79)	.119	-
Supervisor Initiates	3.72 (4,79)	.008	A<G
Mutual Decision	1.02 (4,79)	.404	-
Percent of Time Spent on Nonadvocacy Activities	2.69 (4,79)	.037	B<A

TABLE 17

SUMMARY, ROLE FORM ADVOCATE, PRETEST DATA

(Means with Standard Deviations Given in Parentheses)

ITEM	A-Pre	B-Pre	C-Pre	D-Pre	E-Pre	D-Pre[3]	P-Pre[3]	E-Pre2[4]	F-Pre2[4]	E-Pre Extra[5]
Number of Advocates	19	17	19	19	20	11	7	9	7	9
Number of Applicable Items of 68 total[1]	65.68 (1.00)	65.76 (1.09)	64.95 (1.62)	65.89 (1.49)	65.65 (.88)	65.27 (1.49)	66.86 (1.07)	66.11 (.78)	67.00 (.58)	66.00 (1.00)
Percent of Activities in which Advocate is Involved	29.21 (17.39)	40.35 (17.36)	40.37 (18.53)	44.53 (17.40)	36.75 (16.25)	27.45 (10.58)	41.43 (14.62)	34.78 (13.24)	58.43 (22.01)	34.78 (10.07)
Reasons of Noninvolvement[2]										
Perceived as Inappropriate	6.68 (7.87)	2.71 (3.50)	12.05 (17.63)	7.00 (12.81)	6.55 (6.45)	3.34 (3.61)	2.43 (2.37)	4.33 (3.67)	4.29 (5.19)	3.22 (2.73)
Blocked Administratively	.89 (3.07)	1.65 (5.15)	4.11 (8.54)	3.63 (4.67)	2.70 (6.33)	3.91 (11.70)	.43 (1.13)	1.11 (2.20)	.29 (.76)	1.44 (2.30)
Not Planned For	19.11 (21.79)	36.18 (16.50)	31.63 (16.80)	24.16 (22.73)	24.55 (23.12)	23.73 (16.79)	28.57 (11.01)	17.33 (11.54)	34.43 (17.05)	25.00 (13.51)
Someone Else Responsible for Activity	66.84 (27.53)	57.58 (17.79)	48.74 (22.51)	61.42 (27.19)	59.70 (27.07)	68.45 (18.04)	64.14 (9.58)	73.22 (12.12)	58.29 (20.43)	65.22 (15.16)
Other	6.58 (22.28)	1.82 (4.82)	3.47 (6.81)	3.84 (8.65)	6.45 (10.60)	.18 (.60)	4.57 (5.03)	4.00 (4.56)	2.70 (3.7)	4.78 (4.87)
How Advocate is Involved[2]										
Performing the Activity Only	27.00 (22.83)	67.53 (19.47)	43.42 (22.91)	15.37 (15.33)	27.95 (19.81)	41.00 (24.38)	49.29 (12.11)	20.67 (21.70)	11.57 (12.62)	12.44 (12.05)
Advocating the Activity Only	23.21 (19.39)	16.71 (9.98)	25.11 (21.26)	17.68 (12.53)	14.45 (12.46)	30.73 (22.03)	38.43 (15.67)	16.44 (12.41)	34.29 (18.19)	24.33 (15.75)
Mixture of Performing and Advocating	44.37 (29.36)	15.82 (15.54)	31.53 (26.09)	67.05 (21.55)	57.60 (20.54)	28.18 (18.75)	12.57 (9.83)	63.00 (18.67)	54.43 (23.78)	63.33 (20.81)
Total Performance- Perform only plus more perform than advocate	49.95 (26.31)	77.76 (11.87)	62.37 (20.28)	56.95 (16.99)	63.55 (17.06)	52.09 (23.31)	53.57 (13.55)	53.00 (20.12)	46.71 (19.41)	57.11 (20.28)
Total Advocacy- Advocate Only plus more advocate than perform	44.79 (25.76)	22.24 (11.87)	37.58 (20.24)	43.05 (16.99)	36.50 (16.99)	47.91 (23.31)	46.43 (13.55)	47.00 (20.12)	53.29 (19.41)	42.89 (20.28)
Who Decides Activity will be Performed[2]										
Advocate decides	23.95 (31.22)	54.59 (36.27)	40.95 (35.56)	23.68 (19.47)	19.50 (28.89)	59.00 (39.78)	75.71 (27.68)	25.11 (23.27)	31.29 (37.21)	26.44 (25.01)
Supervisor decides	16.37 (24.17)	1.65 (3.53)	11.11 (19.69)	17.47 (25.76)	20.20 (24.27)	16.73 (27.58)	1.14 (1.95)	28.78 (19.47)	22.43 (38.29)	40.22 (32.21)
Mutual Decision	54.37 (31.62)	43.76 (36.67)	48.05 (32.49)	58.74 (33.93)	60.35 (35.58)	24.27 (33.58)	23.14 (28.50)	46.11 (34.16)	46.29 (40.57)	33.11 (31.11)
Median Percent of Time Spent on Non-Advocacy Activities	75-100%	50-75%	50-75%	25-50%	50-75%	50-75%	50-75%	50-75%	50-75%	50-75%
Percent of all Activities of which Advocate is Aware that these are part of the Health Component	76.95 (20.13)	88.47 (12.75)	81.47 (22.11)	71.63 (27.69)	87.20 (16.21)	82.55 (16.69)	90.43 (11.27)	59.22 (29.00)	72.71 (35.52)	79.56 (13.24)
Sources of Knowledge of Activities										
Health Advocacy Training (HAT)	1.58 (4.45)	1.24 (4.60)	.26 (1.15)	.79 (3.44)	.50 (2.24)	.00 (.00)	.00 (.00)	.00 (.00)	.00 (.00)	.00 (.00)
Formal Education (other than HAT)	8.26 (14.16)	12.76 (22.79)	12.42 (20.82)	8.21 (13.38)	10.05 (22.04)	7.36 (10.75)	2.29 (2.50)	11.11 (22.07)	6.57 (11.43)	3.67 (5.10)
On-the-job Training	67.26 (27.78)	60.47 (31.13)	53.37 (26.11)	55.32 (25.75)	72.00 (27.84)	63.00 (29.48)	70.86 (14.95)	68.33 (26.84)	68.57 (36.22)	76.78 (21.45)
Life Experience	22.58 (26.79)	24.88 (28.06)	33.89 (24.35)	35.47 (25.76)	17.45 (17.89)	29.36 (25.76)	26.14 (14.79)	20.44 (9.17)	10.86 (12.09)	19.56 (17.64)
Other	.32 (1.00)	.82 (2.04)	.11 (.46)	.11 (.46)	0.00 (0.00)	.36 (.81)	.71 (1.25)	.22 (.67)	.00 (.00)	.00 (.00)

[1] These are the activities of the 68 activities in the Role Form which are applicable to a particular site, and on which scoring of the site is based.
[2] These are mean percentages of response to each alternative.
[3] First pretest one year before training.
[4] Second pretest on sites originally tested a year before training.
[5] Sites added to Cycle E just before training.

TABLE 18

CONTRASTS AMONG PRE SCORES OF CYCLES A, B, C, D, AND G ON THE ROLE FORM ADVOCATE

Score	F Test (df in parentheses)	Two-tailed P value	Tukey Honestly Significant Difference, $\alpha = .05$
Percent of Activities Appropriate for Site	1.67 (4,89)	.165	-
Percent of Activities in Which Advocate is Involved	2.07 (4,89)	.091	-
Reasons of Noninvolvement			
Perceived as Inappropriate	1.68 (4,89)	.162	-
Blocked Administratively	.98 (4,89)	.425	-
Lack of Planning	1.96 (4,89)	.108	-
Someone Else Responsible	1.34 (4,89)	.262	-
Other	.50 (4,89)	.733	-
How Advocate is Involved in Activity			
Perform Only	17.54 (4,89)	$< .001$	A<B, C<B, D<B, G<B, D<C
Advocate Only	1.56 (4,89)	.191	-
Mixture of Advocating and Performing	14.02 (4,89)	$< .001$	B<A, A<D, B<D, B<G, C<D, C<G
Total Performance	5.09 (4,89)	.001	A<B, D<B
Total Advocacy	3.84 (4,89)	.006	B<A, B<D
Who Decides Activity Will Be Performed			
Advocate Initiates	4.20 (4,89)	.004	A<B, D<B, G<B
Supervisor Initiates	2.10 (4,89)	.088	-
Mutual Decision	.79 (4,89)	.538	-
Percent of Time Spent on Nonadvocacy Activities	2.26 (4,89)	.069	D<A
Percent of Activities of Which Advocate is Informed That They are Part of the Health Component	2.20 (4,89)	.076	-
Sources of Information			
Health Advocacy Training	.469(4,89)	.758	-
Other Formal Education	.243(4,89)	.243	-
On The Job Training	1.57 (4,89)	.189	-
Life Experience	1.86 (4,89)	.124	-
Other	1.86 (4,89)	.124	-

TABLE 19

SUMMARY OF SUPERVISOR PRE-TEST OPINION SURVEYS

Data Included are Those of the First Administration of the Test to Each Supervisor Whether or Not the Supervisor Subsequently Retook the Test in Association With a Later Trained Site (Means With Standard Deviations Given Below in Parentheses)

Cycle	Number of Supervisors	Attitude Scores 1	2	3	4	5	6	7	8	9	10	Total Score
A	16	4.63 (1.36)	3.88 (1.67)	3.25 (1.48)	2.75 (1.00)	2.69 (1.30)	4.38 (.72)	2.62 (1.15)	3.56 (1.50)	2.13 (1.20)	2.44 (1.50)	32.31 (5.85)
B	15	4.53 (.99)	3.27 (1.33)	2.47 (1.36)	2.47 (1.19)	3.13 (.74)	4.20 (1.01)	2.27 (1.16)	3.47 (1.12)	2.07 (.96)	2.07 (.96)	29.93 (3.28)
C	11	5.00 (1.48)	4.00 (1.41)	3.09 (1.30)	2.64 (1.63)	2.64 (1.29)	3.55 (.82)	2.91 (1.38)	3.55 (1.04)	2.82 (1.33)	2.18 (1.08)	32.36 (5.28)
D	12	4.33 (.98)	3.42 (1.56)	3.33 (.49)	3.08 (1.44)	3.08 (.51)	3.92 (1.08)	3.58 (2.07)	3.58 (1.16)	2.67 (.98)	3.17 (.58)	34.17 (4.22)
G	14	4.64 (1.08)	3.86 (1.17)	3.21 (1.12)	2.86 (.95)	2.21 (1.25)	4.50 (.85)	2.43 (1.28)	3.36 (1.01)	2.64 (1.60)	1.93 (.92)	31.64 (5.92)
EF[1]	10	4.80 (.79)	2.80 (1.14)	3.10 (1.29)	2.90 (1.52)	2.90 (.88)	3.90 (.88)	3.30 (.48)	3.20 (1.23)	2.40 (1.43)	2.20 (1.03)	31.50 (6.11)

NOTE: Maximum score per scale = 9. Maximum total = 90. Scores of zero are ideal, indicating complete compliance with advocacy attitudes.

1. Combines all first administrations of the Opinion Survey to supervisors whose sites were trained together as Cycle EF.

TABLE 20

CONTRASTS AMONG PRE SCORES OF CYCLES A, B, C, D and G
ON THE SUPERVISOR HEALTH OPINION SURVEY (N=68)

Attitude	F Test with (4,63) df	Two-Tailed p value	Tukey Honestly Significant Difference $\alpha = .05$
1. Health issues can be grasped by non-health personnel.	.475	.754	-
2. Health providers will negotiate to provide service.	.668	.617	-
3. Health providers are trained individuals who sell their skills to consumers.	1.181	.328	-
4. Alternative sources of health information are available.	.466	.760	-
5. Personal health information may be collected if it will be used to benefit the individual.	1.674	.167	-
6. Strategies exist to obtain health services.	2.222	.077	-
7. Planning can be effective.	1.720	.157	-
8. A multi-disciplinary approach to health problem solution is desirable.	.082	.988	-
9. It is appropriate to foster independence rather than encourage dependency.	1.053	.387	-
10. The Advocate should disseminate health information to others.	2.611	.044	-
TOTAL	1.237	.304	G < D

Note: Low scores indicate greater approximation to ideal attitudes.

Table 20

TABLE 21

SUMMARY OF PRE-TEST SCORES, HEALTH OPINION SURVEY, ADVOCATE
(Means with Standard Deviations Given Below in Parentheses)

Cycle	Number of Cases	Attitude Being Tapped [1] 1	2	3	4	5	6	7	8	9	10	Total [2] Score
A	19	4.37 (1.12)	3.58 (.90)	2.95 (.78)	3.37 (1.50)	2.89 (1.20)	4.32 (1.38)	2.95 (1.18)	3.95 (1.58)	2.63 (1.38)	1.95 (1.31)	32.95 (6.32)
B	18	3.61 (.78)	3.56 (1.38)	3.06 (1.43)	3.89 (1.08)	2.61 (1.04)	4.27 (.83)	3.28 (1.41)	3.44 (.98)	2.28 (1.27)	2.44 (1.10)	32.44 (5.15)
C	18	4.00 (1.28)	2.94 (1.43)	2.56 (1.38)	3.17 (1.34)	2.72 (.96)	4.33 (1.19)	3.00 (1.24)	3.67 (1.64)	2.56 (1.29)	2.22 (1.00)	31.17 (6.32)
D	18	4.61 (1.61)	3.39 (1.29)	2.72 (1.02)	3.50 (1.24)	2.89 (.96)	4.56 (.98)	3.22 (1.06)	4.00 (1.41)	2.78 (1.63)	2.33 (1.08)	34.00 (5.72)
G	19	4.74 (1.33)	3.21 (1.44)	3.16 (1.46)	3.47 (1.31)	2.63 (1.01)	4.42 (1.02)	2.68 (1.20)	3.79 (1.18)	2.95 (1.31)	2.05 (1.18)	33.11 (4.42)
E [3]	11	4.73 (1.10)	3.45 (1.63)	3.64 (1.63)	3.36 (1.43)	2.55 (1.29)	4.18 (1.17)	2.73 (1.68)	5.09 (1.76)	3.36 (2.06)	2.91 (1.45)	36.00 (6.37)
F [3]	7	4.71 (1.60)	4.71 (1.97)	3.43 (1.72)	3.86 (.90)	3.00 (.58)	4.14 (.38)	3.86 (.38)	4.43 (1.40)	3.00 (.82)	3.00 (.58)	38.14 (2.97)
E [4]	8	5.00 (.93)	3.38 (1.41)	3.25 (.71)	3.63 (1.19)	2.88 (.64)	3.50 (1.31)	3.50 (.53)	3.88 (.99)	3.00 (.76)	3.00 (.76)	35.00 (5.45)
F [4]	7	4.00 (.56)	4.14 (1.07)	3.00 (.58)	3.86 (.90)	3.14 (.38)	4.29 (.95)	3.29 (1.11)	3.57 (1.27)	2.57 (.53)	2.43 (1.13)	34.29 (4.46)
Ex [5]	9	5.11 (1.27)	4.11 (2.09)	3.00 (1.12)	3.22 (1.72)	1.67 (.87)	4.11 (.78)	2.55 (1.42)	3.22 (1.39)	1.89 (1.36)	1.89 (1.17)	30.78 (5.87)

[1] The maximum session score is 9 with an ideal score of zero.
[2] The maximum total score is 90 with an ideal score of zero.
[3] These are the first pre test scores on the E and F site advocates who were not trained until one year following this pretest.
[4] These are the second pretest scores on the E and F sites tested just prior to training.
[5] These are sites added to Cycle E at the time of training.

TABLE 22

CONTRASTS AMONG PRE-SCORES OF CYCLES A, B, C, D AND G
ON THE ADVOCATE HEALTH OPINION SURVEY (N=92)

Attitude	F Test with (4,87) df	p Value	Tukey Honestly Significant Difference $\alpha = .05$
1. Health issues can be grasped by non-health personnel.	2.474	<.05	B<G[1]
2. Health providers will negotiate to provide service.	.752	NS	-
3. Health providers are trained individuals who sell their skills to consumers.	.718	NS	-
4. Alternative sources of health information are available.	.738	NS	-
5. Personal health information may be collected if it will be used to benefit the individual.	.318	NS	-
6. Strategies exist to obtain health services.	.185	NS	-
7. Planning can be effective.	.701	NS	-
8. A multi-disciplinary approach to health problem solution is desirable.	.478	NS	-
9. It is appropriate to foster independence rather than encourage dependency.	.604	NS	-
10. The Advocate should disseminate health information to others.	.508	NS	-
TOTAL	.616	NS	-

[1]Low socres indicate greater approximation to ideal attitudes.

Table 22

TABLE 23

SUMMARY OF PRETEST SCORES, HEALTH KNOWLEDGE TEST, ADVOCATE
(Means with Standard Deviations Given in Parentheses)

Cycle	Number of Cases	Item Cluster Scores 1	2	3	4	5	6	7	8	9	10	Total Score
A-Pre	19	4.68 (1.77)	3.37 (1.16)	3.95 (.78)	3.68 (1.55)	3.47 (1.26)	4.68 (1.67)	4.21 (1.81)	3.74 (1.41)	4.08 (1.20)	4.95 (1.35)	41.42 (8.23)
B-Pre	17	5.94 (1.25)	3.76 (1.35)	4.41 (1.28)	4.04 (2.02)	3.29 (1.26)	5.35 (1.17)	4.06 (1.50)	3.12 (1.41)	4.88 (1.76)	5.12 (1.45)	43.98 (10.02)
C-Pre	19	5.79 (1.55)	3.58 (1.64)	4.00 (.82)	4.07 (2.02)	3.68 (1.25)	5.47 (1.54)	3.83 (1.45)	3.47 (1.58)	4.47 (1.78)	5.32 (1.42)	43.69 (8.77)
D-Pre	19	5.47 (1.50)	3.32 (1.20)	3.95 (1.35)	4.43 (1.70)	3.89 (.99)	4.47 (1.54)	3.90 (1.38)	2.26 (1.56)	3.74 (1.73)	5.05 (1.27)	40.48 (8.67)
G-Pre	20	5.15 (1.35)	3.30 (1.22)	4.45 (1.00)	4.68 (1.98)	3.35 (1.46)	4.45 (1.15)	3.86 (1.29)	2.95 (1.57)	4.75 (1.21)	4.85 (1.87)	41.80 (8.50)
E-Pre[1]	11	3.91 (1.87)	2.64 (1.69)	3.36 (1.50)	2.85 (2.36)	3.18 (1.72)	4.18 (1.89)	4.23 (1.42)	2.27 (1.49)	3.64 (2.06)	4.18 (1.66)	34.44 (11.43)
F-Pre[1]	7	4.86 (1.46)	3.43 (.98)	3.71 (.95)	3.02 (1.52)	3.29 (.95)	5.00 (1.29)	3.99 (1.80)	3.71 (1.25)	3.29 (1.38)	5.43 (.79)	39.73 (6.99)
E-Pre[2]	9	4.00 (1.73)	3.44 (1.59)	2.78 (1.20)	3.24 (1.73)	3.22 (1.20)	5.00 (1.58)	3.28 (.96)	2.89 (1.62)	3.78 (1.09)	4.56 (1.51)	36.18 (7.49)
F-Pre[2]	7	5.14 (.90)	3.14 (.90)	4.43 (.79)	4.83 (1.45)	3.29 (.95)	4.86 (1.07)	4.55 (1.62)	4.43 (1.27)	5.00 (1.29)	6.00 (1.15)	45.67 (5.89)
E-Pre[3]	9	5.22 (1.20)	3.22 (1.48)	4.33 (.71)	4.80 (1.48)	2.89 (1.27)	4.33 (2.24)	4.20 (1.19)	2.56 (1.51)	3.78 (1.64)	4.46 (1.01)	39.88 (4.96)

Note: Maximum score per subject is 8.0 Maximum total score is 80.0
[1]These are the original pre test scores of E and F sites as tested one year prior to training.
[2]These are the second pre test scores of E and F sites originally tested one year prior to training and pre-tested again just before entering training.
[3]These are the first pre-test scores of sites added to Cycle E just before training.

TABLE 24

CONTRASTS AMONG PRE SCORES OF CYCLES A, B, C, D AND G ON THE ADVOCATE HEALTH KNOWLEDGE TEST (N = 94)

Item Cluster	F Test with (4,89) df	p Value	Tukey Honestly Significant Difference α = .05
1. Advocacy, Health Records.	2.113	$<.10$	-
2. Daily Health Check, Common Health Problems.	.414	NS	-
3. Screening Tests, Immunizations, Medication Administration	1.091	NS	-
4. Poisoning, Ear and Hearing Problems	.828	NS	-
5. Environmental Quality and Safety, Vision Screening	.730	NS	-
6. Nutrition, Dental Health, Mental Health	2.203	$<.10$	-
7. Recognition and Management of Minor Illness, Organizational Approaches to Health Care.	.222	NS	-
8. Children with Special Needs	2.646	$<.05$	D<A
9. Health Policies, Safety Surveillance, Emergency Preparedness, First Aid, Transportation Safety.	1.607	NS	-
10. Health Education	.271	NS	-
TOTAL	.534	NS	-

Table 24

TABLE 25

SUMMARY OF TRAINEE INFORMATION ON
TRAINED ADVOCATES WHO WERE EVALUATED ONE YEAR LATER

	Pilot	A	B	C	D	G	E_4^1	F_4^1	E_N^1	Total
AGE OF TRAINEE										
Number Responding	10	15	12	17	14	15	5	4	8	100
21 to 30	30%	33%	50%	41%	21%	13%	60%	50%	50%	35%
31 to 40	40%	33%	50%	23%	21%	13%	20%	0%	38%	28%
41 to 50	30%	27%	0%	29%	43%	53%	0%	25%	12%	28%
51 and Over	0%	7%	0%	6%	14%	20%	20%	25%	0%	9%
SEX OF TRAINEE										
Number Responding	10	15	12	17	14	15	5	4	8	100
Male	0%	20%	8%	0%	7%	13%	20%	0%	12%	9%
Female	100%	80%	92%	100%	93%	87%	80%	100%	88%	91%
MARITAL STATUS										
Number Responding	10	15	12	17	14	15	5	4	8	100
Single	10%	27%	42%	29%	14%	7%	60%	25%	12%	23%
Married	50%	47%	58%	41%	50%	67%	40%	75%	63%	53%
Divorced	20%	20%	0%	6%	14%	7%	0%	0%	12%	10%
Separated	20%	7%	0%	12%	0%	13%	0%	0%	12%	8%
Widowed	0%	0%	0%	12%	21%	7%	0%	0%	0%	6%

[1] E_4 and F_4 data represent post training data collected from trainees who were evaluated one year prior to training (E_1/F_1) and just prior to training (E_2/F_2); E_N represents the trainees who joined the E/F Cycle just prior to training.

	Pilot	A	B	C	D	G	E	F	E_N	Total
AGE OF OLDEST CHILD										
Number Responding	9	13	6	8	11	11	2	3	5	68
0 to 1 year	0%	8%	0%	0%	0%	0%	0%	0%	0%	1%
2 to 5 years	0%	8%	33%	25%	0%	0%	0%	33%	0%	9%
6 to 9 years	0%	8%	0%	0%	9%	0%	0%	0%	40%	6%
10 to 12 years	22%	8%	17%	0%	9%	9%	0%	0%	0%	9%
13 and Over	78%	69%	50%	75%	82%	91%	100%	67%	60%	75%
AGE OF YOUNGEST CHILD										
Number Responding	9	13	6	8	11	11	2	3	5	68
0 to 1 year	0%	8%	0%	0%	0%	0%	0%	0%	0%	1%
2 to 5 years	22%	15%	33%	25%	0%	0%	0%	33%	40%	16%
6 to 9 years	33%	31%	33%	12%	36%	9%	50%	0%	20%	25%
10 to 12 years	11%	0%	0%	0%	18%	9%	0%	0%	20%	7%
13 and Over	33%	1%	33%	63%	45%	82%	50%	57%	20%	50%
NUMBER OF CHILDREN										
Number Responding	10	15	12	17	13	15	5	4	8	99
0	10%	13%	50%	53%	23%	27%	60%	25%	38%	32%
1	10%	27%	17%	18%	8%	7%	20%	25%	0%	14%
2	0%	7%	17%	6%	31%	40%	20%	25%	38%	19%
3	20%	20%	8%	18%	15%	20%	0%	0%	25%	16%
4	30%	27%	0%	6%	8%	0%	0%	25%	0%	10%
5	0%	7%	0%	0%	0%	7%	0%	0%	0%	2%
More than 5	30%	0%	8%	0%	15%	0%	0%	0%	0%	6%

Table 25

TABLE 25--SUMMARY OF TRAINEE INFORMATION ONE-YEAR LATER (Cont'd)

	Pilot	A	B	C	D	G	E	F	E_N	Total
HIGHEST ACADEMIC CERTIFICATION										
Number Responding	10	15	12	17	14	15	5	4	8	100
Grade 9 to 11	0%	7%	0%	0%	0%	0%	0%	0%	0%	1%
High School Graduate or GED	10%	13%	17%	6%	7%	13%	0%	0%	25%	11%
Some College	30%	47%	33%	53%	36%	60%	60%	25%	25%	43%
Associate Degree	20%	0%	0%	6%	0%	0%	0%	0%	0%	3%
Undergraduate Degree	10%	27%	25%	29%	36%	20%	20%	50%	38%	27%
Professional or Trade Certificate	30%	7%	8%	0%	14%	7%	20%	0%	12%	10%
Master's Degree	0%	0%	17%	6%	7%	0%	0%	25%	0%	5%
NUMBER OF COLLEGE CREDITS (Of Those Attending But Not Completing College)										
Number Responding	3	6	3	8	4	8	2	1	2	37
0 to 15 credits	0%	50%	0%	38%	58%	12%	0%	100%	0%	27%
16 to 30 credits	0%	33%	0%	12%	25%	25%	50%	0%	0%	19%
31 to 60 credits	100%	17%	100%	50%	25%	12%	50%	0%	0%	38%
61 to 90 credits	0%	0%	0%	0%	0%	50%	0%	0%	50%	13%
91 credits and over	0%	0%	0%	0%	0%	0%	0%	0%	50%	3%

	Pilot	A	B	C	D	G	E	F	E_N	Total
NATURE OF HIGHEST DEGREES, CERTIFICATIONS OR LICENSES HELD										
Number Responding	6	5	6	8	9	6	2	3	5	50
Child Development	33%	0%	17%	25%	22%	0%	0%	0%	0%	14%
Elementary Education	0%	0%	0%	12%	0%	0%	0%	67%	40%	10%
Secondary Education	0%	40%	0%	12%	0%	0%	50%	0%	0%	8%
Business	17%	0%	0%	0%	0%	0%	0%	0%	0%	2%
Nursing	33%	0%	17%	0%	22%	33%	50%	33%	0%	18%
Social Work	17%	0%	50%	38%	33%	67%	0%	0%	20%	30%
Liberal Arts	0%	0%	17%	0%	11%	0%	0%	0%	0%	4%
Psychology	0%	20%	0%	12%	0%	0%	0%	0%	20%	6%
Other[2]	0%	40%	0%	0%	11%	0%	0%	0%	20%	8%
NURSING CERTIFICATION										
Number Responding	9	15	12	17	14	15	5	4	8	99
Registered Nurse	11%	0%	8%	0%	7%	7%	0%	0%	0%	4%
Licensed Practical Nurse	11%	0%	8%	0%	7%	13%	20%	0%	0%	6%
No Nursing Certification	78%	100%	83%	100%	86%	80%	80%	100%	100%	90%

[2]Cycle A, Religion, Clerical; Cycle D, Home Economics; Cycle E_N, Psychiatric Art Therapy.

Table 25

TABLE 25--SUMMARY OF TRAINEE INFORMATION ONE-YEAR LATER (Cont'd)

	Pilot	A	B	C	D	G	E	F	E_N	Total
CURRENT TITLE OF TRAINEE BY JOB CLASSIFICATION Number Responding	10	15	12	17	14	15	5	4	8	
Administration: Director, Asst. Director, Program Administrator, Program Supervisor, Administrative Assistant.	0%	13%	0%	29%	7%	7%	40%	50%	0%	13%
Clerical: Secretarial	0%	7%	0%	6%	0%	0%	0%	0%	0%	2%
Education: Teacher, Asst. Teacher Teacher Aide, Child Care Worker, Caregiver, Group Worker	50%	47%	42%	29%	7%	7%	20%	25%	25%	28%
Social Service: Social Worker, Asst. Social Worker, Social Worker Aide, Parent Contact Worker, Family Worker, Parent Coordinator, Social Service Worker, Case Worker, Home Visitor, Community Aide, Case-Worker Aide, Social Worker Trainee.	30%	33%	42%	35%	64%	73%	40%	25%	75%	48%
Health: R.N., L.P.N., Health Coordinator	20%	0%	17%	0%	21%	13%	0%	0%	0%	9%
SALARY OF TRAINEE Number Responding	8	13	12	14	12	14	5	3	8	89
Less than $5,000	0%	8%	0%	0%	17%	7%	0%	33%	12%	6%
$5,000 to $7,000	63%	54%	42%	29%	8%	0%	0%	0%	0%	25%
$7,001 to $10,000	25%	23%	42%	50%	50%	57%	60%	33%	50%	44%
$10,001 to $15,000	12%	15%	17%	21%	25%	36%	40%	33%	38%	25%

TABLE 26
SUMMARY HSCC POST-TEST SCORES
(Means With Standard Deviations Given Below in Parentheses)

Score	Pilot-Post	A-Post	B-Post	C-Post	D-Post	G-Post	E-Post[1]	F-Post
Number of Sites[2]	11	18	17	20	18	21	15	5
External Planning Scale Score	54.55 (29.19)	51.25 (28.65)	54.41 (23.78)	54.35 (25.73)	42.11 (16.77)	45.00 (22.82)	43.75 (19.36)	60.00 (28.50)
Special Needs Scale Score (of programs having special needs children)	63.64 (31.17)	47.39 (34.34)	57.18 (34.50)	49.00 (30.74)	56.33 (31.35)	54.62 (40.51)	71.73 (35.77)	65.20 (25.90)
Number of Types of Special Needs (of all programs)	4.73 (2.45)	4.30 (2.34)	5.35 (1.97)	3.86 (2.14)	3.89 (2.66)	3.76 (2.47)	5.40 (2.50)	5.20 (1.79)
Number of Incidences of Special Needs (of programs having special needs children)	31.54 (58.86)	16.00 (21.03)	36.24 (49.08)	12.95 (12.59)	14.44 (22.02)	17.86 (34.37)	27.33 (36.12)	13.00 (10.42)
Number of Children with Special Needs (of programs having special needs children)	8.55 (16.53)	9.22 (10.83)	19.12 (20.72)	6.30 (6.67)	13.72 (26.02)	11.48 (18.43)	19.80 (21.46)	8.00 (2.12)
Number of Programs with Special Needs Children	11	18	17	20	18	21	15	5
Internal Planning Scale Score	94.73 (11.73)	98.60 (4.31)	94.12 (10.25)	81.44 (23.72)	88.63 (16.33)	82.80 (21.85)	94.69 (14.58)	94.20 (12.97)
Advocate named as directly responsible for planning health component	.45	.30	.65	.26	.32	.32	.25	.60
Advocate among those listed as responsible for planning health compnent (including those named as directly responsible)	.82	.90	.94	.70	.79	.80	.88	.80
Percent of Programs Furnishing Health Services-Screening	91%	95%	100%	74%	95%	68%	94%	100%
Health Services Screening Scale Score (of all programs)	63.09 (28.10)	59.00 (34.08)	67.00 (29.81)	48.83 (36.72)	44.79 (28.90)	30.96 (33.59)	47.19 (32.66)	33.20 (13.88)
Health Services Screening Consent Subscore (of programs providing screening)	33.90 (42.97)	12.37 (24.02)	8.00 (20.56)	27.17 (40.15)	35.44 (45.05)	55.00 (40.35)	65.40 (37.71)	0.00 (0.00)
Percent of Services Provided by Program	60.60 (25.07)	51.16 (31.23)	57.00 (30.89)	55.06 (29.02)	35.72 (24.05)	40.59 (31.28)	47.93 (29.71)	31.00 (14.77)
Number of Programs Providing Screening	10	19	17	17	18	17	15	5

TABLE 26--SUMMARY OF HSCC POST-TEST SCORES (Cont'd)

Score	Pilot-Post	A-Post	B-Post	C-Post	D-Post	E-Post	F-Post	G-Post
Percent of Programs Providing Medical Evaluation and Treatment	91%	95%	100%	100%	100%	96%	100%	100%
Medical Evaluation and Treatment Scale Score (of all programs)	77.09 (35.41)	75.95 (35.95)	80.76 (25.38)	64.52 (38.15)	66.26 (40.89)	71.04 (39.68)	86.56 (23.39)	81.80 (25.81)
Consent Subscore(of programs providing medical evaluation and treatment)	49.20 (39.13)	11.63 (16.85)	22.18 (32.93)	18.30 (29.07)	20.63 (28.38)	38.42 (36.41)	35.69 (32.41)	10.80 (17.41)
Escort Subscore(of programs providing medical evaluation and treatment)	80.10 (15.14)	81.63 (19.88)	86.24 (13.39)	74.78 (19.33)	70.21 (25.77)	68.04 (24.99)	79.38 (16.50)	93.20 (9.31)
Percent of Services Program Provides(of programs providing medical evaluation and treatment)	48.40 (36.13)	47.32 (30.83)	51.29 (35.44)	36.96 (35.57)	30.32 (27.87)	33.08 (33.05)	52.63 (34.53)	38.00 (17.55)
Number of Programs Providing Medical Evaluation and Treatment	10	19	17	23	19	24	16	5
Medical Records Process Scale Score	76.27 (17.44)	67.40 (20.64)	70.41 (16.33)	62.17 (25.75)	62.58 (17.54)	58.92 (23.44)	71.25 (15.52)	70.00 (12.33)
Health Policies and Procedures Scale Score	72.35 (19.47)	72.15 (16.59)	66.71 (19.48)	61.89 (20.63)	68.74 (20.32)	62.24 (18.42)	70.13 (13.84)	68.80 (14.75)
Health Education Scale Score	69.64 (25.45)	85.45 (12.28)	82.00 (15.91)	69.61 (20.31)	72.37 (14.78)	66.72 (22.34)	75.81 (10.61)	83.20 (8.81)
Staff Health Scale Score	76.27 (9.57)	73.15 (16.00)	69.29 (14.53)	69.04 (13.82)	76.84 (8.10)	69.88 (15.38)	77.44 (7.09)	77.40 (13.39)
Dental Care Scale Score	75.00 (18.68)	77.50 (27.44)	69.94 (20.76)	62.65 (33.71)	67.95 (25.83)	64.56 (34.02)	77.38 (26.71)	75.00 (17.68)
Evacuation, Emergency, and Disaster Plan Score	69.09 (10.44)	59.50 (24.81)	64.12 (21.81)	48.26 (26.22)	61.05 (18.83)	62.80 (26.22)	63.12 (14.93)	60.00 (20.00)
First Aid Scale Score	87.64 (16.40)	77.20 (24.07)	79.06 (20.34)	74.57 (29.70)	74.16 (33.21)	69.64 (28.91)	70.88 (34.87)	78.00 (24.29)
Percent Trained in First Aid of Those Required (may exceed 100% if more people trained than are required)	132.91 (100.34)	134.50 (116.29)	106.94 (67.40)	132.87 (97.54)	116.42 (86.91)	121.04 (100.00)	106.13 (74.63)	121.80 (92.85)
First Aid Equipment Subscale Score	75.00 (19.36)	78.75 (23.33)	77.94 (17.42)	76.09 (15.95)	81.58 (23.34)	78.00 (20.82)	71.88 (23.94)	85.00 (13.69)
Environmental Quality and Safety Scale Score	78.09 (9.67)	73.80 (11.78)	68.24 (7.74)	74.57 (7.39)	75.11 (8.90)	77.40 (6.83)	78.81 (9.03)	82.64 (8.23)
Nutrition Scale Score	63.36 (16.00)	63.80 (14.19)	63.06 (15.32)	67.17 (10.81)	65.84 (16.78)	67.16 (13.82)	66.88 (13.63)	65.20 (15.88)
Menu Subscore								
Percent of Programs Providing Routine Transportation	100%	95%	100%	91%	95%	88%	100%	100%
Routine Transportation Scale Score(of programs providing routine transportation)	79.09 (17.43)	75.63 (9.79)	68.71 (16.88)	69.81 (13.49)	81.50 (13.90)	75.68 (9.44)	77.38 (13.93)	88.40 (15.88)
Medical Records Content Scale Score	39.89 (7.75)	42.55 (15.09)	44.65 (17.27)	47.09 (13.22)	50.89 (11.62)	47.08 (16.01)	54.53 (11.41)	59.60 (9.91)
Number of Programs for Which Records Could Be Scored	9	20	17	22	18	25	15	5

NOTE: All Scale Scores have maximum of 100, indicating complete compliance.

1. This includes all sites trained in Cycle E whether or not they were pretested a year prior to training.
2. All available post data are included.

TABLE 27

PRE-POST CHANGE ANALYSIS--HSCC

(All sites included for which both pre and post data available, n=123)

Score		Means(S.D. in parentheses) Pre	Post	t	df	p (two-tailed)
External Planning Scale Score	$\bar{x}$	37.40	49.39	4.13	122	.001
	s	(25.08)	(23.62)			
Special Needs Scale Score[1]	$\bar{x}$	32.25	56.07	5.37	222	.001
	s	(32.18)	(34.16)			
	n	112	112			
Number of Types of Special Needs[1]	$\bar{x}$	4.04	4.63	2.08	222	.05
	s	(1.99)	(2.25)			
	n	112	112			
Number of Incidences of Special Needs[1]	$\bar{x}$	20.53	20.20	-.07	222	NS
	s	(37.32)	(31.00)			
	n	112	112			
Number of Children with Special Needs[1]	$\bar{x}$	13.39	12.87	-.19	222	NS
	s	(23.55)	(18.23)			
	n	112	112			
Internal Planning and Administration Scale Score	$\bar{x}$	82.89	89.55	3.25	122	.01
	s	(22.47)	(17.94)			
Advocate Named as Responsible for Health Component (proportion of programs)	$\bar{x}$	.230	.340	2.71	122	.01
	s	(.42)	(.48)			
Advocate Among Those Listed as Planning Health Component (proportion of programs)	$\bar{x}$	.49	.82	6.20	122	.001
	s	(.50)	(.39)			
Proportion of Programs Providing Screening Tests		.81	.86	1.54	122	NS
Health Services Screening Scale Score	$\bar{x}$	34.99	47.96	3.74	122	.001
	s	(30.50)	(33.71)			
Health Services Screening Consent Score[1]	$\bar{x}$	26.63	31.00	.79	203	NS
	s	(39.86)	(39.79)			
	n	99	106			
Percent of Appropriate Screening Tests Program Provides[1]	$\bar{x}$	40.57	47.12	1.64	203	NS
	s	(28.08)	(29.13)			
	n	99	106			
Proportion of Programs Providing Medical Evaluation and Treatment		.92	.98	2.35	122	.02
Medical Evaluation and Treatment Scale Score	$\bar{x}$	53.09	74.02	5.46	122	.001
	s	(36.49)	(35.01)			
Medical Evaluation and Treatment Consent Subscore[1]	$\bar{x}$	23.26	24.07	.19	232	NS
	s	(32.10)	(30.95)			
	n	113	121			
Medical Evaluation and Treatment Escort Subscore[1]	$\bar{x}$	68.12	76.92	2.58	232	.01
	s	(30.21)	(21.50)			
	n	113	121			
Percent Medical Evaluation and Treatment Items Program Provides[1]	$\bar{x}$	41.66	40.77	-.20	232	NS
	s	(33.60)	(32.86)			
	n	113	121			

TABLE 27--PRE-POST CHANGE ANALYSIS--HSCC (Cont'd)

Score		Pre	Post	t	df	p (two-tailed)
Medical Record Process Scale Score	$\bar{x}$ s	53.18 (22.44)	64.96 (20.56)	6.46	122	.001
Health Policies and Procedures Scale Score	$\bar{x}$ s	48.68 (21.55)	67.29 (18.11)	8.48	122	.001
Health Education Scale Score	$\bar{x}$ s	64.34 (21.84)	74.76 (17.81)	5.41	122	.001
Staff Health Scale Score	$\bar{x}$ s	65.54 (19.79)	72.66 (13.01)	5.20	122	.001
Dental Care Scale Score	$\bar{x}$ s	61.27 (27.44)	68.99 (25.[illegible])	3.11	122	.01
Emergency, Evaluation and Disaster Plan Scale Score	$\bar{x}$ s	43.18 (23.68)	59.51 (23.11)	4.72	122	.001
First Aid Scale Score	$\bar{x}$ s	54.51 (16.47)	74.24 (28.16)	5.74	122	.001
Percent Trained in First Aid of Those Required	$\bar{x}$ s	81.77 (100.21)	120.76 (91.80)	3.87	122	.001
First Aid Equipment Subscore	$\bar{x}$ s	71.34 (26.33)	77.64 (20.94)	2.24	122	.05
Environmental Quality and Safety Scale Score	$\bar{x}$ s	72.02 (10.60)	74.98 (9.10)	3.01	122	.01
Nutrition Scale Score	$\bar{x}$ s	62.50 (16.96)	69.76 (17.89)	2.32	122	.05
Menu Subscore	$\bar{x}$ s	61.45 (31.86)	70.63 (31.74)	3.51	122	.001
Proportion of Programs Providing Routine Transportation		.93	.94	.38	122	NS
Transportation Scale Score[1]	$\bar{x}$ s n	70.35 (17.11) 115	75.35 (13.82) 116	2.45	229	.02
Medical Records Content Score[1]	$\bar{x}$ s n	31.82 (15.21) 122	48.13 (14.52) 120	8.53	249	.001

Note: Maximum value of each scale score is 100, which score indicates complete compliance.

1. For five scales, Special Needs, Health Services-Screening, Health Services-Medical Evaluation and Treatment, Routine Transportation, Medical Records Content, these scores were deleted for programs to which they did not apply, eg. programs with no special needs children, programs providing no transportation. To test pre-post change, these data were analyzed with non-repeated measures t-tests using all available data.

TABLE 28

SUMMARY ROLE FORM, SUPERVISOR, POST TEST DATA
(Means With Standard Deviations Given Below in Parentheses)

Item	Pilot Post	A-Post	B-Post	C-Post	D-Post	G-Post	E-Post[3]	F-Post
Number of Supervisors	9	9	16	16	13	13	10	3
Number of Applicable Items of 68 total[1]	66.11 (1.05)	66.16 (.96)	66.44 (.89)	66.25 (.93)	66.54 (1.13)	65.31 (1.49)	66.10 (.74)	66.33 (2.08)
Percent of Activities in which Advocate is involved	65.33 (14.59)	59.21 (16.33)	59.75 (19.81)	50.06 (22.58)	57.85 (14.31)	62.31 (20.84)	50.60 (19.16)	81.00 (16.09)
Reasons of Non-involvement[2]								
Perceived as inappropriate	6.44 (6.21)	5.74 (4.57)	2.88 (3.28)	5.88 (6.83)	10.00 (22.27)	14.08 (27.89)	3.60 (3.66)	2.33 (4.04)
Blocked Administratively	4.33 (5.63)	2.26 (7.28)	1.13 (2.09)	.81 (1.42)	4.15 (5.47)	2.15 (4.78)	4.70 (4.97)	.00 (.00)
Not Planned for	7.22 (7.95)	22.32 (24.90)	13.81 (8.79)	21.19 (21.90)	16.15 (18.77)	23.31 (21.56)	17.70 (10.13)	67.00 (40.36)
Someone else responsible for activity	70.22 (17.10)	64.58 (23.67)	74.06 (15.26)	70.69 (27.09)	66.31 (24.81)	53.31 (28.05)	71.70 (10.60)	30.67 (41.59)
Other	11.77 (13.69)	5.21 (9.58)	8.38 (15.24)	1.38 (2.06)	3.77 (3.90)	7.00 (9.59)	2.30 (6.29)	0.00 (0.00)
How Advocate is Involved[2]								
Performing the activity only	33.56 (19.16)	15.89 (17.22)	21.31 (16.60)	20.75 (14.88)	20.46 (15.15)	23.00 (22.79)	18.50 (20.65)	34.67 (26.54)
Advocating the activity only	18.33 (11.41)	23.16 (16.57)	21.56 (7.48)	19.44 (18.18)	31.23 (10.62)	25.23 (12.72)	24.10 (7.88)	31.00 (18.33)
Mixture of performing and advocating	48.00 (22.64)	61.11 (22.52)	57.38 (16.04)	59.81 (23.64)	48.38 (16.99)	51.85 (24.91)	57.70 (22.96)	34.00 (35.59)
Total performance- perform only plus more perform than advocate	60.67 (10.92)	54.26 (18.35)	58.44 (12.14)	54.50 (16.13)	52.62 (14.82)	50.62 (18.32)	44.70 (18.40)	47.00 (19.16)
Total Advocacy- advocate only plus more advocate then perform	39.33 (10.92)	45.74 (18.35)	41.56 (12.14)	45.50 (16.13)	47.38 (14.82)	49.38 (18.32)	55.20 (18.32)	53.00 (19.16)
Who decides Activity will be performed[2]								
Advocate decides	15.56 (23.68)	10.68 (14.92)	22.94 (25.49)	14.75 (15.29)	42.46 (32.19)	12.54 (20.93)	26.60 (27.75)	41.33 (51.43)
Supervisor decides	49.44 (42.87)	36.74 (38.37)	28.50 (32.28)	35.00 (38.39)	12.77 (27.57)	30.85 (39.50)	33.70 (39.71)	14.00 (22.54)
Mutual decision	34.78 (35.36)	52.68 (40.13)	48.50 (32.22)	50.19 (37.82)	44.85 (36.17)	56.62 (40.87)	39.50 (32.35)	45.00 (40.36)
Median Percent of Time spent on Non-advocacy activities	75-100%	50-75%	25-50%	50-75%	50-75%	25-50%	50-75%	25-50%

[1] These are the activities of the 68 activities in the Role Form which are applicable to a particular site and on which scoring of the site is based.
[2] These are mean percentages of response to each alternative.
[3] E-Post combines sites originally in Cycle E, i.e., tested, not trained, then retested a year later just prior to training, plus sites added to Cycle E just prior to training.

TABLE 29

PRE-POST CHANGE ANALYSIS OF THE ROLE FORM SUPERVISOR (N=70)

Score	Pre-Test Mean	Post-Test Mean	F Test (1,69)df	Two-tailed p value
Percent of Activities Appropriate for Site	65.71	66.21	6.12	<.05
Percent of Activities in Which Advocate is Involved	41.21	58.53	66.92	<.001
Reasons of Noninvolvement				
Perceived as Inappropriate	5.40	7.20	.94	NS
Blocked Administratively	2.40	2.07	.16	NS
Lack of Planning	25.01	22.16	1.41	NS
Someone Else Responsible	65.19	64.07	.29	NS
Other	1.87	4.54	4.13	<.005
How Advocate is Involved in Activity				
Perform Only	36.57	19.71	19.92	<.001
Advocate Only	20.36	23.94	3.39	<.10
Mixture of Performing and Advocating	41.63	56.44	12.07	<.001
Total Performance	59.76	51.60	12.46	<.001
Total Advocacy	38.79	48.39	18.43	<.001
Who Decides Activity Will be Performed				
Advocate Decides	27.76	22.09	2.19	NS
Supervisor Decides	16.41	29.71	2.85	<.10
Mutual Decision	54.39	48.24	1.76	NS
Percent of Time Spent on Nonadvocacy Activities[1]	50-75%	50-75%	1.02	NS

1. Analysis of variance was run on ranks of response, ie 1=1-10%, 2=11-25%, 3=25-50%, 4=50-75%, 5=75-100%. Means of ranks were 3.93 and 3.77 for pre and post means, respectively.

TABLE 30

SUMMARY ROLE FORM, ADVOCATE, POST TEST DATA
(Means With Standard Deviations Given Below in Parentheses)

Item	Pilot-Post	A-Post	B-Post	C-Post	D-Post	G-Post	E-Post[3]	F-Post
Number of Advocates	9	19	16	18	17	20	13	4
Number of Applicable Items of 68 total[1]	66.22 (.97)	66.16 (.96)	66.44 (.89)	66.28 (.75)	66.47 (1.12)	65.35 (1.14)	66.00 (.71)	67.25 (.50)
Percent of Activities in which Advocate is involved	59.44 (23.02)	58.37 (14.42)	61.75 (21.31)	55.56 (18.60)	56.29 (20.16)	55.15 (18.21)	55.77 (14.39)	83.50 (5.92)
Reasons of Non-involvement								
Perceived as inappropriate	6.00 (4.58)	4.63 (7.26)	5.63 (4.16)	5.28 (7.18)	7.82 (18.77)	4.80 (9.75)	4.85 (4.83)	6.25 (12.50)
Blocked Administratively	5.56 (8.88)	2.95 (7.28)	1.50 (4.31)	1.33 (2.68)	.47 (1.50)	.15 (.67)	3.85 (5.37)	3.25 (6.50)
Not planned for	12.44 (8.38)	22.89 (22.18)	20.75 (11.19)	22.22 (11.99)	12.47 (9.67)	21.95 (21.44)	16.46 (14.90)	27.25 (26.20)
Someone Else Responsible for Activity	67.33 (17.42)	62.05 (25.57)	64.69 (15.32)	62.61 (17.54)	75.41 (21.92)	64.35 (30.78)	72.85 (15.20)	63.50 (43.71)
Other	9.00 (13.42)	7.37 (10.38)	7.63 (8.02)	8.67 (10.69)	3.82 (4.59)	8.70 (10.87)	2.00 (3.34)	.00 (.00)
How Advocate is Involved[2]								
Performing the Activity only	35.67 (26.21)	21.11 (17.16)	28.50 (22.19)	15.78 (17.58)	13.64 (13.29)	29.45 (25.79)	16.77 (18.33)	15.25 (13.94)
Advocating the Activity only	14.11 (5.04)	23.89 (9.20)	17.19 (7.62)	22.33 (15.02)	26.29 (14.32)	24.65 (10.23)	25.77 (11.43)	25.50 (21.99)
Mixture of Performing and Advocating	50.33 (23.52)	55.05 (20.25)	54.32 (19.18)	61.89 (19.73)	60.12 (21.75)	45.80 (18.76)	57.23 (19.81)	59.00 (34.62)
Total Performance- Perform only plus more perform than advocate	64.89 (18.59)	52.37 (15.28)	65.63 (17.18)	46.83 (17.44)	44.53 (14.55)	51.50 (22.13)	41.54 (18.59)	52.25 (20.85)
Total Advocacy- advocate only plus more advocate than perform	35.11 (18.59)	47.63 (15.28)	34.38 (17.18)	53.17 (17.44)	55.47 (14.55)	48.50 (22.13)	58.46 (18.59)	47.75 (20.85)
Who Decides Activity will be Performed[2]								
Advocate decides	34.78 (24.80)	15.79 (13.69)	30.44 (28.91)	26.83 (24.67)	21.65 (17.28)	31.45 (32.43)	26.31 (29.83)	37.00 (44.61)
Supervisor decides	19.56 (20.27)	19.32 (26.19)	14.94 (22.19)	34.39 (31.04)	38.29 (34.59)	26.70 (35.61)	34.15 (41.20)	26.50 (30.99)
Mutual decision	45.78 (36.38)	65.11 (31.49)	54.75 (28.52)	38.72 (30.13)	40.06 (33.46)	41.90 (36.66)	39.69 (32.67)	36.50 (20.73)
Median Percent of Time spent on non-advocacy activities	25-50%	50-75%	25-50%	50-75%	25-50%	25-50%	25-50%	25-50%
Percent of all activities of which Advocate is aware that these are part of the health component	95.78 (5.63)	96.21 (5.37)	89.13 (24.42)	95.33 (6.94)	98.00 (3.10)	92.15 (12.67)	94.85 (12.69)	100.00 (.00)
Sources of Knowledge of Activities								
Health Advocacy Training (HAT)	59.33 (18.25)	66.11 (37.50)	60.56 (37.13)	55.06 (35.53)	51.35 (26.36)	38.80 (26.42)	47.38 (20.96)	51.50 (15.63)
Formal Education (other than HAT)	2.00 (5.29)	5.95 (16.33)	6.81 (11.67)	1.22 (3.78)	3.35 (5.56)	7.50 (13.76)	1.08 (2.10)	13.00 (25.34)
On-the-job training	29.33 (21.75)	23.16 (27.69)	27.94 (30.31)	26.39 (28.82)	28.59 (17.10)	37.05 (17.06)	39.69 (21.25)	26.50 (19.84)
Life Experience	9.33 (8.78)	4.79 (11.45)	4.81 (12.41)	12.33 (17.56)	16.76 (14.77)	16.40 (18.91)	12.08 (11.81)	8.75 (14.89)
Other	.00 (.00)	.00 (.00)	.00 (.00)	5.00 (21.21)	.00 (.00)	.30 (1.34)	.00 (.00)	.00 (.00)

[1] These are the activities of the 68 activities in the role form which are applicable to a particular site and on which scoring of the site is based.
[2] These are mean percentages of response to each alternative.
[3] E-Post combines sites originally in Cycle E, i.e., tested, not trained, then retested a year later just prior to training, plus sites added to Cycle E just prior to training.

TABLE 31

PRE-POST CHANGE ANALYSIS OF THE ROLE FORM ADVOCATE (N=90)

Score	Pre-Test Mean	Post-Test Mean	F Test with (1,89) df	Two-Tailed p value
Percent of Activities Appropriate for Site	65.68	66.12	9.88	$<.005$
Percent of Activities in Which Advocate Is Involved	38.61	58.77	138.61	$<.001$
Reasons of Noninvolvement				
Perceived as Inappropriate	6.86	5.48	1.41	NS
Blocked Administratively	1.77	1.84	.01	NS
Lack of Planning	24.08	18.57	9.48	$<.005$
Someone Else Responsible	63.82	68.03	4.03	$<.05$
Other	3.50	6.10	5.25	$<.05$
How Advocate is Involved In Activity				
Perform Only	32.67	18.93	23.21	$<.001$
Advocate Only	21.48	23.48	1.01	NS
Mixture of Performing and Advocating	45.86	57.53	12.25	$<.001$
Total Performance	60.52	48.84	27.35	$<.001$
Total Advocacy	39.48	51.16	27.35	$<.001$
Who Decides Activity Will Be Performed				
Advocate Decides	28.49	24.68	1.36	NS
Supervisor Decides	18.13	27.26	5.87	$<.05$
Mutual Decision	53.34	48.12	1.31	NS
Percent of Time Spent on Nonadvocacy Activities[1]	50-75%	25-50%	14.64	$<.001$
Percent of Activities of Which Advocate Is Informed That They are Part of the Health Component	79.93	97.07	61.61	$<.001$
Sources of Information				
Health Advocacy Training	.79	58.56	416.76	$<.001$
Other Formal Education	8.93	3.88	7.72	$<.01$
On The Job Training	65.10	28.00	125.38	$<.001$
Life Experience	25.08	9.62	39.99	$<.001$
Other	.17	.00	no test possible[2]	-

1. Analaysis of variance performed on ranks of response, ie 1=1-10%, 2=11-25%, 3=25-50%, 4=51-75%, 5=76-100%. Means of these ranks were 3.94 and 3.32 for pre and post scores, respectively.

2. The fact of zero variance prevents the performance of an analysis of variance.

TABLE 32

SUMMARY OF SUPERVISOR POST-TEST OPINION SURVEYS

Data Included are Those Scores of the First Administration of the Post-Test To Each Supervisor Whether or Not the Supervisor Subsequently Retook the Test In Association With a Later Trained Site

(Means With Standard Deviations Given Below In Parentheses)

Cycle	Number of Supervisors	Attitude Scores 1	2	3	4	5	6	7	8	9	10	Total Score
Pilot	3	5.67 (1.15)	3.00 (1.00)	3.67 (.58)	2.00 (1.73)	3.00 (1.00)	3.67 (.58)	3.00 (1.73)	3.67 (.58)	1.67 (1.53)	2.33 (1.15)	31.67 (10.40)
A	16	4.88 (1.50)	3.63 (1.31)	3.81 (.75)	3.94 (1.06)	3.00 (.63)	4.62 (1.02)	3.38 (1.45)	3.69 (1.85)	2.69 (1.58)	2.75 (1.00)	35.38 (6.11)
B	11	4.64 (1.36)	2.64 (1.69)	2.55 (1.37)	3.73 (1.35)	2.36 (1.43)	4.36 (.81)	3.00 (.89)	3.55 (1.69)	2.27 (1.27)	2.45 (2.25)	31.55 (6.38)
C	10	4.80 (1.23)	4.20 (1.14)	3.40 (.52)	2.70 (.82)	3.30 (.82)	4.00 (.94)	3.30 (1.06)	3.40 (1.17)	2.10 (.88)	2.30 (1.25)	33.50 (3.87)
D	10	4.20 (1.14)	3.20 (2.66)	2.60 (1.71)	3.30 (.95)	2.70 (1.34)	4.60 (.97)	2.70 (1.25)	3.60 (1.43)	2.70 (1.49)	3.10 (1.37)	32.70 (8.68)
C	13	5.23 (1.54)	3.46 (.66)	2.77 (1.09)	3.00 (1.15)	2.62 (1.19)	4.69 (1.49)	2.31 (1.38)	3.62 (1.33)	2.08 (1.66)	1.92 (1.44)	31.69 (7.93)
EF[1]	8	3.88 (.99)	3.38 (1.60)	3.00 (.93)	2.62 (1.41)	2.75 (1.58)	3.50 (1.41)	3.38 (.74)	3.25 (1.28)	2.25 (1.75)	2.25 (1.28)	30.25 (9.48)

NOTE: Maximum score per scale = 9. Maximum total = 90. Scores of zero are ideal, indicating complete compliance with advocacy standards.

1. Combines all post-test administrations of the Opinion Survey to supervisors.

TABLE 33

PRE POST ANALYSIS OF THE SUPERVISOR OPINION SCALE

All Supervisors With Pre-Test and One-Year Post-Test Scores (N=49)

Attitude	Pre Mean	Post Mean	F Test (1,48) df	P Value
1	4.80	4.78	.01	NS
2	3.78	3.53	1.02	NS
3	3.20	2.98	1.55	NS
4	2.73	2.92	1.43	NS
5	2.78	2.76	.01	NS
6	4.14	4.45	2.29	NS
7	2.59	2.78	.82	NS
8	3.37	3.47	.47	NS
9	2.45	2.20	1.55	NS
10	2.43	2.35	.16	NS
Total	32.27	32.20	.01	NS

NOTE: If a supervisor had more than one site, only his data from the first site for which he responded are included. Maximum score is 9 per attitude, 90 for total. Scores of zero are ideal, indicating complete compliance with advocacy attitudes.

TABLE 34

SUMMARY OF ADVOCATE FIRST POST-TEST SCORES, HEALTH OPINION SURVEY
Immediately Following Training
(Means With Standard Deviations Given Below in Parentheses)

Cycle	Number of Cases	Attitude Scores[1] 1	2	3	4	5	6	7	8	9	10	Total[2] Score
A	3	3.67 (.58)	4.00 (1.00)	3.00 (0.00)	3.67 (.58)	2.00 (1.73)	3.33 (1.15)	2.67 (2.31)	6.00 (1.73)	2.67 (.58)	1.67 (1.53)	32.67 (4.93)
B	12	2.42 (.79)	2.83 (1.47)	2.42 (.90)	3.50 (1.45)	2.42 (1.08)	3.67 (1.30)	2.67 (1.15)	3.67 (1.23)	2.67 (1.30)	2.08 (1.16)	29.33 (6.87)
C	16	2.63 (1.50)	3.06 (1.53)	2.94 (1.24)	3.19 (1.22)	2.31 (1.01)	4.25 (1.48)	3.13 (1.31)	2.69 (1.58)	1.94 (1.57)	2.00 (1.59)	28.13 (8.23)
D	10	3.10 (.88)	3.10 (.88)	2.80 (.92)	3.10 (1.10)	2.10 (.88)	4.90 (1.10)	2.80 (1.32)	3.50 (1.18)	2.20 (1.32)	1.90 (1.29)	29.50 (5.70)
G	17	3.65 (1.06)	4.00 (1.66)	3.18 (.73)	2.94 (1.43)	2.82 (1.07)	4.29 (1.40)	3.12 (1.11)	4.00 (1.54)	2.41 (1.42)	2.41 (1.18)	32.82 (7.46)
E[3]	13	4.38 (1.12)	3.46 (1.76)	2.85 (1.41)	3.23 (1.30)	2.38 (1.50)	4.54 (1.45)	3.08 (1.38)	3.54 (1.90)	2.00 (1.47)	1.85 (1.14)	31.31 (8.51)
F	5	4.20 (1.10)	4.00 (.71)	3.40 (.55)	4.00 (.71)	3.00 (1.00)	4.00 (.71)	3.00 (.71)	3.20 (.45)	3.20 (.45)	3.00 (.71)	35.00 (3.39)

[1] The maximum attitude score is 9 with an ideal score of zero.
[2] The maximum total score is 90 with an ideal score of zero.
[3] These scores include original Cycle E sites plus added sites.

TABLE 35

SUMMARY OF ADVOCATE POST-TEST SCORES, HEALTH OPINION SURVEY
One-Year After Training
(Means With Standard Deviations Given Below in Parentheses)

CYCLE	NUMBER OF CASES	ATTITUDE SCORES[1] 1	2	3	4	5	6	7	8	9	10	TOTAL SCORE[2]
A	19	3.74 (1.52)	2.89 (1.63)	2.84 (1.77)	3.26 (1.76)	2.63 (1.26)	4.42 (1.02)	2.68 (1.63)	3.58 (1.64)	2.63 (1.01)	2.05 (1.22)	30.74 (8.53)
B	16	3.38 (1.36)	3.19 (1.42)	2.81 (.91)	3.31 (1.01)	2.38 (1.15)	4.69 (1.30)	2.81 (1.38)	3.75 (1.44)	2.88 (1.26)	2.38 (1.09)	31.56 (6.75)
C	17	3.06 (1.56)	2.82 (1.29)	2.71 (.77)	3.06 (.97)	2.82 (1.13)	3.94 (1.48)	3.18 (1.07)	3.00 (1.66)	2.06 (1.25)	2.35 (1.54)	29.00 (6.87)
D	16	4.06 (1.77)	3.69 (1.20)	3.06 (.85)	3.69 (1.30)	2.63 (1.09)	4.63 (.62)	3.50 (1.26)	4.13 (1.31)	2.50 (1.10)	2.31 (1.14)	34.19 (5.46)
G	20	4.00 (1.26)	3.80 (1.06)	3.15 (.75)	3.80 (1.47)	2.70 (.98)	4.65 (1.04)	2.90 (1.29)	4.05 (1.00)	2.60 (1.19)	2.15 (1.18)	33.80 (5.47)
E[3]	13	4.69 (1.93)	3.38 (1.66)	2.85 (1.34)	3.23 (1.36)	2.15 (1.41)	4.23 (1.17)	3.23 (1.09)	3.54 (1.61)	2.31 (2.10)	2.23 (1.42)	31.85 (7.94)
F	4	3.75 (.96)	3.75 (.96)	3.50 (.58)	4.00 (1.41)	3.50 (.58)	3.75 (.50)	3.00 (.82)	3.00 (1.83)	2.75 (.50)	2.75 (1.26)	33.75 (5.12)

[1]The maximum attitude score is 9 with an ideal score of zero.
[2]The maximum total score is 90 with an ideal score of zero.
[3]E-Post scores combines sites originally in Cycle F, i.e., tested, not trained, then retested a year later just prior to training, plus sites added to Cycle E just prior to training.

TABLE 36

PRE, $POST_1$, $POST_2$ CHANGE ANALYSIS OF THE HEALTH OPINION SURVEY--ADVOCATE DATA (N=61)

Attitude	(1) Pre Mean	(2) Post[1] Mean	(3) Post[2] Mean	F Test (2,120)df	p Value	Tukey Honestly Significant Difference (α = .05)	
1	4.43	3.51	3.56	18.17	< .001	(1) > (2)	(1) > (3)
2	3.41	3.54	3.39	.38	NS	-	
3	2.90	2.98	2.85	.38	NS	-	
4	3.61	3.31	3.28	2.75	< .10	-	
5	2.59	2.51	2.57	.22	NS	-	
6	4.16	4.36	4.26	.74	NS	-	
7	3.02	3.02	3.03	.01	NS	-	
8	3.70	3.56	3.46	.93	NS	-	
9	2.69	2.31	2.31	3.11	< .05	-	
10	2.39	2.16	2.34	1.08	NS	-	
Total	32.90	31.26	31.11	4.21	< .05	(1) > (2)	(1) > (3)

NOTE: Maximum score is 9 per attitude, 90 for total. Scores of zero are ideal, indicating complete compliance with advocacy attitudes.

1. Test immediately after training.
2. Test one year following training.
3. (1) Pre Mean; (2)=First post mean; (3)=Second post mean

TABLE 37

PRE POST ANALYSIS OF THE ADVOCATE OPINION SCALE OF ALL ADVOCATES WITH PRE SCORES AND POST SCORES ONE YEAR FOLLOWING TRAINING (N=95)

Attitude	Pre Mean	Post Mean[1]	F (1,94)	p Value
1	4.36	3.77	11.45	< .005
2	3.41	3.29	.46	NS
3	2.97	2.89	.26	NS
4	3.51	3.44	.19	NS
5	2.72	2.60	1.13	NS
6	4.28	4.39	.59	NS
7	3.03	3.00	.05	NS
8	3.77	3.60	1.29	NS
9	2.57	2.51	.16	NS
10	2.26	2.30	.09	NS
Total	32.87	31.80	3.03	< .10

NOTE: Maximum score per scale = 9; maximum total =90; Scores of zero are ideal, indicating complete compliance with advocacy attitudes.

1. Test one year following the pretest.

TABLE 38

INDIVIDUAL ITEM CONTRASTS OF PRE VERSUS FIRST POST RESPONSES BY ADVOCATES ON THE HEALTH OPINION SURVEY

(N=73 Advocates With Complete Pre and First Post-Test Protocols)

Attitude	Item	Pre Test Mean	Post Test Mean	Ideal Answer	t test (Post-Pre) With 72 df	Two-tailed P Value	Direction Of Change
	1	2.96	3.10	4	1.79	NS	
1	2	2.93	2.51	1	-4.12	.001	expected
	3	2.60	2.95	4	4.36	.001	expected
	4	2.75	2.70	4	-.16	NS	
2	5	2.73	2.71	4	-.13	NS	
	6	3.16	3.11	4	-.56	NS	
	7	1.84	1.75	1	-.92	NS	
3	8	3.14	3.01	4	-1.69	NS	
	9	2.82	2.79	4	-.33	NS	
	10	2.42	2.44	4	.15	NS	
4	11	2.12	1.89	1	-3.25	.01	expected
	12	1.81	1.71	1	-1.62	NS	
	13	3.25	3.19	4	-.85	NS	
5	14	2.10	2.05	1	-.41	NS	
	15	3.27	3.41	4	-2.09	.05	expected
	16	2.77	2.74	4	-.30	NS	
6	17	3.08	2.95	1	-1.28	NS	
	18	1.93	2.03	1	1.35	NS	
	19	1.85	1.79	1	-.63	NS	
7	20	3.27	3.37	4	1.41	NS	
	21	2.58	2.44	4	-1.12	NS	
	22	2.84	2.81	4	-.33	NS	
8	23	2.44	2.37	1	-.84	NS	
	24	2.96	3.01	4	.50	NS	
	25	2.69	3.12	4	1.54	NS	
9	26	3.22	3.19	4	-.41	NS	
	27	1.92	1.62	1	-3.48	.001	expected
	28	3.27	3.36	4	1.03	NS	
10	29	1.93	1.95	1	.17	NS	
	30	1.66	1.56	1	-1.41	NS	

Note: Mean responses were calculated by averaging observed responses scored with 1 = Strongly Agree; 2 = Agree; 3 = Disagree; 4 = Strongly Disagree.

Table 38

TABLE 39

HEALTH KNOWLEDGE TEST, ADVOCATE

Summary of Post-Test Scores Immediately After Training
(Means With Standard Deviations in Parentheses)

CYCLE	NUMBER OF CASES	ITEM CLUSTER SCORES[1] 1	2	3	4	5	6	7	8	9	10	TOTAL[2] SCORE
Pilot- Post 1	8	5.38 (1.85)	3.50 (.76)	4.13 (.99)	4.04 (1.81)	4.13 (1.64)	5.13 (1.46)	3.73 (1.72)	3.75 (1.49)	5.25 (1.16)	4.13 (1.89)	43.15 (9.87)
A-Post 1	16	6.44 (1.50)	5.38 (1.54)	6.13 (1.20)	5.80 (1.68)	5.31 (1.49)	6.00 (1.10)	6.27 (1.62)	4.88 (1.89)	5.31 (2.06)	5.25 (2.57)	56.76 (11.71)
B-Post 1	13	6.38 (1.19)	6.46 (1.33)	6.46 (1.33)	6.28 (1.19)	6.69 (1.03)	6.62 (1.12)	6.38 (.98)	6.54 (1.85)	6.85 (1.07)	6.77 (1.01)	64.43 (7.98)
C-Post 1	16	6.69 (1.49)	6.19 (1.52)	5.94 (1.84)	6.34 (1.19)	5.81 (1.60)	6.44 (1.41)	6.49 (1.17)	6.31 (1.58)	6.75 (1.18)	6.44 (1.09)	63.39 (9.38)
D-Post 1	14	6.86 (1.23)	4.93 (1.77)	6.57 (1.22)	6.04 (1.55)	5.86 (1.29)	6.07 (1.73)	5.47 (1.13)	4.57 (2.03)	6.07 (1.82)	6.36 (1.08)	58.78 (10.20)
G-Post 1	18	6.00 (1.41)	4.89 (1.28)	5.83 (1.79)	5.53 (1.41)	5.61 (1.54)	6.33 (1.71)	5.80 (1.81)	5.28 (1.71)	5.61 (1.94)	5.61 (1.46)	57.49 (11.46)
E-Post 1[3]	14	6.21 (1.42)	4.71 (1.77)	5.43 (1.55)	6.05 (1.41)	5.57 (1.45)	6.07 (1.77)	5.68 (1.47)	4.50 (1.61)	5.43 (1.91)	5.57 (1.50)	55.23 (9.22)
F-Post 1	5	6.40 (.89)	5.60 (.55)	6.20 (1.30)	7.07 (1.13)	5.40 (1.82)	6.60 (.89)	6.67 (1.51)	6.20 (1.48)	6.00 (1.00)	7.00 (1.22)	63.13 (4.99)

[1] Maximum score per session in 8.0.
[2] Maximum total score is 80.0
[3] E-Post scores combine sites originally in Cycle E, i.e., tested, not trained, then retested a year later just prior to training, plus sites added to Cycle E just prior to training.

TABLE 40

HEALTH KNOWLEDGE TEST, ADVOCATE
Summary of Post-Test Scores One Year After Training
(Means With Standard Deviations in Parentheses)

Cycle	Number of Cases	ITEM CLUSTER Scores[1] 1	2	3	4	5	6	7	8	9	10	Total[2] Score
Pilot-Post 2	9	5.56 (1.33)	4.56 (1.13)	5.00 (.87)	4.61 (1.41)	4.11 (1.45)	5.11 (1.54)	4.43 (.90)	3.78 (1.30)	5.33 (1.22)	5.22 (1.72)	47.71 (8.28)
A-Post 2	18	6.11 (1.37)	4.94 (1.80)	5.11 (2.03)	5.66 (1.84)	4.78 (1.56)	5.56 (1.79)	5.35 (1.53)	4.72 (2.35)	5.83 (1.82)	5.94 (1.59)	54.01 (14.18)
B-Post 2	16	6.44 (.89)	5.44 (1.50)	5.75 (1.69)	5.96 (1.69)	5.56 (1.82)	6.13 (1.71)	5.53 (1.64)	4.81 (2.17)	6.06 (1.39)	6.44 (1.26)	58.11 (12.33)
C-Post 2	17	6.59 (1.06)	5.76 (1.68)	5.76 (1.35)	6.03 (1.45)	6.00 (1.58)	6.06 (1.48)	6.01 (1.66)	5.65 (1.50)	6.18 (1.42)	6.00 (1.50)	60.04 (10.52)
D-Post 2	16	6.63 (1.20)	5.13 (1.75)	5.06 (1.57)	6.23 (1.53)	5.25 (1.69)	5.81 (1.83)	5.24 (1.33)	4.06 (1.65)	5.75 (2.02)	6.06 (1.81)	55.21 (11.13)
G-Post 2	19	5.95 (2.07)	4.47 (1.93)	4.84 (1.74)	4.99 (2.39)	4.42 (2.01)	5.37 (1.74)	4.73 (2.04)	3.95 (2.07)	5.21 (2.07)	6.05 (1.68)	49.98 (15.52)
E-Post 2[3]	13	6.00 (1.73)	5.15 (1.82)	5.23 (1.17)	5.74 (2.09)	4.54 (1.51)	6.08 (1.55)	5.49 (1.82)	5.31 (1.55)	4.92 (1.75)	5.77 (1.54)	54.23 (11.08)
F-Post 2	4	5.75 (.96)	5.00 (1.15)	5.25 (1.26)	6.58 (1.26)	6.00 (1.15)	6.25 (.50)	6.17 (1.04)	5.75 (2.06)	5.50 (.58)	7.00 (1.15)	59.25 (4.87)

[1] Maximum score per session is 8.0
[2] Maximum total score is 80.0
[3] E-post scores combine sites originally in Cycle E, i.e., tested, not trained, then retested one year later just prior to training, plus sites added to Cycle E just prior to training.

TABLE 41

PRE, $POST_1$, $POST_2$ CHANGE ANALYSIS OF THE HEALTH KNOWLEDGE TEST - ADVOCATE DATA (N=81)

Item Cluster	(1) Pre Mean	(2) Post 1[1] Mean	(3) Post 2[2] Mean	F Test (2,160 df)	p value	Tukey Honestly Significant[3] Difference (α = .05)
1	5.20	6.42	6.40	33.25	$<$.001	(1)$<$(2), (1)$<$(3)
2	3.48	5.33	5.33	53.52	$<$.001	(1)$<$(2), (1)$<$(3)
3	4.07	6.02	5.47	69.48	$<$.001	(1)$<$(2), (1)$<$(3), (3)$<$(2)
4	4.17	6.08	6.00	78.09	$<$.001	(1)$<$(2), (1)$<$(3)
5	3.47	5.75	5.36	82.06	$<$.001	(1)$<$(2), (1)$<$(3)
6	4.83	6.30	6.04	50.96	$<$.001	(1)$<$(2), (1)$<$(3)
7	3.86	5.98	5.56	82.74	$<$.001	(1)$<$(2), (1)$<$(3), (3)$<$(2)
8	3.19	5.36	5.09	66.72	$<$.001	(1)$<$(2), (1)$<$(3)
9	4.43	5.94	5.80	48.84	$<$.001	(1)$<$(2), (1)$<$(3)
10	4.99	6.23	6.20	35.36	$<$.001	(1)$<$(2), (1)$<$(3)
Total	41.69	59.40	57.24	283.92	$<$.001	(1)$<$(2), (1)$<$(3), (3)$<$(2)

NOTE: Maximum score is 8 per scale, 80 for total.

1. Test immediately after training.
2. Test one year following training.
3. (1) = Pre Mean; (2) = First Post Mean; (3) =Second Post Mean

TABLE 42

PRE POST ANALYSIS OF THE ADVOCATE HEALTH KNOWLEDGE TEST OF ALL ADVOCATES WITH PRE SCORES AND POST SCORES ONE YEAR FOLLOWING TRAINING (N=94)

Session	Pre Mean	Post Mean[1]	F (1,93)	p value
1	5.31	6.29	34.14	$<.001$
2	3.54	5.20	74.58	$<.001$
3	4.11	5.32	47.90	$<.001$
4	4.23	5.85	69.01	$<.001$
5	3.47	5.17	67.19	$<.001$
6	4.84	5.84	38.43	$<.001$
7	3.95	5.43	59.51	$<.001$
8	3.18	4.84	61.58	$<.001$
9	4.43	5.69	59.35	$<.001$
10	5.01	6.10	49.63	$<.001$
Total	42.08	55.73	163.14	$<.001$

NOTE: Maximum score per session = 8.0. Maximum total score = 80.00.

1. Test one year following the pretest.

Table 42

TABLE 43

CORRELATIONS AMONG ADJUSTED CHANGE SCORES OF ADVOCATE OPINION, KNOWLEDGE AND ROLE (DECIMALS OMITTED, N=104)

Table 43

	OPIN	HKT	INV	ADB	ELS	TADV	INAM	NONAD	INF	ADVLS
Opinion Test (OPIN)[1]	-	-41***	-18	-06	11	-06	04	10	-24*	01
Health Knowledge Test (HKT)	-	-	20*	07	-05	09	04	-06	40***	11
Percent of Activities in Which Advocate Involved (INV)	-	-	-	-01	-21*	-01	-00	-22*	27**	27**
Advocate Not Involved Due to Administrative Block (ADB)	-	-	-	-	-21[1]	06	05	10	03	12
Advocate Not Involved As Someone Else is Responsible(ELS)	-	-	-	-	-	26**	-20*	03	05	-01
Total Advocacy (TADV)	-	-	-	-	-	-	-14	02	34***	22*
Advocate or Advocate Plus Supervisor Decide Activity Will Be Done (INAM)	-	-	-	-	-	-	-	02	-06	16
Percent of Time Spent On Nonadvocacy Activities(NONAD)	-	-	-	-	-	-	-	-	-20*	-03
Percent of Activities Advocate Knows to be Part of Health Component (INF)	-	-	-	-	-	-	-	-	-	31**
Advocate Listed As Involved In Planning Health Component(ADVLS)	-	-	-	-	-	-	-	-	-	-

1. The Opinion Test is scored such that high scores are associated with failure to hold advocacy opinion. Hence negative correlations are expected with measures keyed in the opposite direction, ie. HKT,INV,TADV,INAM,INF,ADVLS.
2. This is necessarily a negative correlation due to the structure of the test, that is, the two items involved are mutually exclusive alternatives to the question,"Why are you not involved in the activity?"

TABLE 44

CORRELATIONS AMONG ADJUSTED CHANGE SCORES GENERATED FROM HSCC SCALES
(Decimals omitted, N=104 Cases[2])

Scale	EXPL	SPND	INPL	HSSCR	METVR	MEDRC	HPPR	HLED	FRAD	PERFA	EQUIP	STHL	DENT	EQSA	NUTR	ROTR	MEDCON	EEVA
External Planning (EXPL)	-	-01	09	26**	-03	31**	05	27**	11	01	14	16	07	-01	05	-09	-06	-08
Special Needs (SPND)	-	-	08	13	38***	32**	35***	23*	-02	-01	09	-03	27**	11	-07	14	-03	17
Internal Planning (INPL)	-	-	-	36***	32***	40***	30**	14	09	06	11	01	12	-01	-02	-14	09	27**
Health Services Screening (HSSCR)	-	-	-	-	52***	52***	20*	16	10	-04	10	09	11	-13	-10	-09	05	21*
Medical Evaluation and Treatment (METVR)	-	-	-	-	-	32***	12	12	-06	-07	02	03	17	04	04	-07	08	31**
Medical Records Process (MEDRC)	-	-	-	-	-	-	34***	35***	30**	09	31**	25**	27**	-05	15	-17	15	20*
Health Policies and Procedures (HPPR)	-	-	-	-	-	-	-	33***	22*	19	24**	26**	09	14	12	19	39***	25**
Health Education (HLED)	-	-	-	-	-	-	-	-	17	12	18	24**	38***	07	16	-13	28**	15
First Aid (FRAD)	-	-	-	-	-	-	-	-	-	76[1]	36[1]	15	22*	-01	05	-08	21*	10
Percent Trained in First Aid (PERFA)	-	-	-	-	-	-	-	-	-	-	12	11	20	10	19	03	20*	19*
Equipment Subscore (EQUIP)	-	-	-	-	-	-	-	-	-	-	-	02	-01	02	04	04	20*	02
Staff Health (STHL)	-	-	-	-	-	-	-	-	-	-	-	-	12	24**	18	03	12	21*
Dental Care (DENT)	-	-	-	-	-	-	-	-	-	-	-	-	-	04	-03	-19	00	07
Environmental Quality and Safety (EQSA)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	02	24*	02	07
Nutrition (NUTR)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	00	23*	10
Routine Transportation (ROTR)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	17	06
Medical Records Content (MEDCON)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16
Emergency, Evacuation, and Disaster Plan (EEVA)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

*** $p < .001$
** $p < .01$
* $p < .05$

1. Part-whole correlations for which no significance level is given.
2. N=93 cases for special needs scale score; N=97 cases for Routine Transportation; N=101 cases for Medical Records Content.

TABLE 45

CORRELATIONS OF ADJUSTED CHANGE SCORES OF ADVOCATE OPINIONS, KNOWLEDGE AND ROLE WITH HSCC ADJUSTMENT CHANGE SCORES

(Decimals Omitted; N=104)

HSCC Scale	Opinion[4] Test	Health Knowledge Test	Percent of[1] Activities in which Advocate Involved	Not Involved[1] Due to Administrative Block	Not Involved[1] As Someone Else is Responsible	Total[1] Advocacy	Advocate or Advocate[1] Plus Supervisor Decide Activity Will Be Done	Percent of[1] Time on Non-Advocacy Activities	Percent of Activities[1] Advocate Knows Are In Health Component	Advocate[2] Listed As Involved In Planning
External Planning	-26**	21*	15	-04	-02	-20*	-14	05	11	-12
Special Needs[3]	-01	02	10	-07	20	09	-04	00	00	23*
Internal Planning	00	-16	04	03	11	-02	05	-07	01	06
Health Services Screening	-17	12	11	21*	15	00	-16	-01	01	13
Medical Evaluation and Treatment	00	-06	05	02	33***	26**	-04	-03	07	18
Medical Records Process	-06	-06	10	18	26**	11	-32***	05	11	16
Health Policies and Procedures	-05	06	21	07	12	-01	-07	-12	13	24*
Health Education	-13	25**	35***	16	07	02	05	02	36***	13
Staff Health	03	10	-03	07	25**	22	-23*	12	-04	02
Dental Care	03	-09	02	22*	09	09	-06	00	04	03
Emergency, Evacuation and Disaster Plans	04	-01	10	07	15	06	07	-17	04	17
First Aid	-05	07	14	05	05	06	-07	06	15	04
Percent Trained in First Aid	-01	01	04	01	19	01	-01	02	09	-01
Equipment Subscore	09	-03	20*	-15	08	08	01	-03	20*	18
Environmental Quality and Safety	-05	-06	21*	02	-05	05	01	-04	-05	03
Nutrition	02	02	04	09	23*	07	09	09	02	12
Routine Transportation[3]	-01	06	09	-12	09	-06	-11	02	-09	05
Medical Records Content[3]	11	23*	12	07	14	-02	03	01	18	05
TOTAL CHANGE	-11	06	25*	13	28*	08	-08	-06	14	31**

1. Scores derived from Role Form.
2. HSCC Item 60
3. N=93 cases for Special Needs; N=97 cases for Routine Transportation; N=101 for Medical Records Content.

*** p≤.001
** p≤.01
* p≤.05

4. The Opinion Test is scored such that high scores are associated with failure to hold advocacy opinion. Hence negative correlations are expected with measures keyed in the opposite direction.

TABLE 46

PREDICTION OF HSCC ADJUSTED CHANGE SCORES FROM MEASURES OF ADJUSTED CHANGE IN ADVOCATE OPINION, KNOWLEDGE AND ROLE
(N=104 with pairwise deletion for 4 missing Opinion Test Scores and 5 missing Health Knowledge Scores)
WITH VARIABLES ENTERED IN FREE ORDER

HSCC SCALE		STEP IN ANALYSIS 1	2	3	4	5	6	7	8	9	10
EXTERNAL PLANNING	Variable Entered	OPIN	TADV	INAM	HKT	NONAD	INF	INV	ADVLS	ELS	ADB
	R^2 mult	.066**	.115**	.141**	.160**	.169**	.181**	.189**	.199**	.203*	.203*
	Proportion Gain	-	.048	.026	.019	.009	.013	.008	.010	.004	.000
	b*	-.204*	-.255**	-.174	.154	-	-	-	-	-	-
SPECIAL NEEDS	Variable Entered	ADVLS	ELS	INF	INV	ADB	OPIN	INAM	HKT	TADV	-
	R^2 mult	.051*	.089*	.097*	.109*	.111	.114	.116	.116	.117	-
	Proportion Gain	-	.039	.008	.012	.002	.002	.001	.001	.000	-
	b*	.232*	.227*	-.112	.118	-	-	-	-	-	-
INTERNAL PLANNING	Variable Entered	OPIN	HKT	INF	ELS	INV	INAM	ADB	NONAD	TADV	-
	R^2 mult	.031	.041	.049	.055	.063	.070	.075	.080	.082	-
	Proportion Gain	-	.009	.009	.006	.008	.007	.005	.005	.003	-
	b*	.133	-.106	-	-	-	-	-	-	-	-
HEALTH SERVICES SCREENING	Variable Entered	ADB	ELS	OPIN	INV	INAM	TADV	ADVLS	INF	HKT	NONAD
	R^2 mult	.042*	.084*	.118**	.134*	.147*	.158*	.174*	.183*	.190*	.190*
	Proportion Gain	-	.041	.034	.016	.013	.011	.016	.009	.007	.000
	b*	.244*	.228*	-.186	-	-	-	-	-	-	-
MEDICAL EVALUATION & TREATMENT	Variable Entered	ELS	TADV	ADVLS	INF	INV	ADB	HKT	OPIN	NONAD	INAM
	R^2 mult	.108***	.139***	.159***	.167**	.177**	.182**	.185**	.188*	.190*	.190*
	Proportion Gain	-	.032	.196	.007	.010	.005	.003	.003	.002	.000
	b*	.290**	.151	.144	-	-	-	-	-	-	-

TABLE 46--PREDICTION OF HSCC ADJUSTED CHANGE SCORES (Cont'd)

HSCC SCALE		STEP IN ANALYSIS 1	2	3	4	5	6	7	8	9	10
MEDICAL RECORDS PROCESS	Variable Entered	INAM	ADVLS	ELS	ADB	INV	HKT	OPIN	NONAD	TADV	INF
	R^2 mult	.098**	.146***	.185***	.235***	.248***	.253***	.259***	.263***	.266***	.268**
	Proportion Gain	-	.048	.039	.050	.012	.005	.006	.004	.003	.002
	b*	-.307**	.188*	.252**	.231*	-	-	-	-	-	-
HEALTH POLICIES AND PROCEDURES	Variable Entered	ADVLS	INV	ELS	TADV	ADB	NONAD	INAM	OPIN	INF	-
	R^2 mult	.056*	.078*	.102*	.111*	.119*	.127	.134	.135	.135	-
	Proportion Gain	-	.022	.025	.008	.009	.008	.007	.001	.000	-
	b*	.185	.191	.160	-	-	-	-	-	-	-
HEALTH EDUCATION	Variable Entered	INF	INV	ADB	ELS	NONAD	INAM	ADVLS	HKT	TADV	-
	R^2 mult	.131***	.201***	.226***	.252***	.267***	.275***	.283***	.287***	.291***	-
	Proportion Gain	-	.069	.026	.026	.015	.008	.007	.005	.004	-
	b*	.262**	.319***	.198*	.169	-	-	-	-	-	-
STAFF HEALTH	Variable Entered	ELS	INAM	ADB	HKT	INF	NONAD	ADVLS	TADV	OPIN	INV
	R^2 mult	.063*	.099**	.116**	.129*	.146*	.154*	.159*	.164*	.166	.167
	Proportion Gain	-	.036	.017	.013	.017	.008	.005	.005	.002	.001
	b*	.241*	-.194*	.133	-	-	-	-	-	-	-
EMERGENCY, EVACUATION AND DISASTER PLANS	Variable Entered	ELS	NONAD	ADVLS	ADB	INAM	INV	INF	OPIN	HKT	-
	R^2 mult	.034	.063*	.090*	.102*	.109	.116	.121	.122	.122	-
	Proportion Gain	-	.029	.027	.012	.007	.007	.005	.001	.000	-
	b*	..215*	-.178	.149	.115	-	-	-	-	-	-
FIRST AID	Variable Entered	INF	INV	NONAD	ELS	ADB	INAM	ADVLS	TADV	-	-
	R^2 mult	.022	.033	.045	.054	.058	.061	.062	.063	-	-
	Proportion Tain	-	.011	.012	.009	.004	.003	.001	.000	-	-
	b*	.120	.108	-	-	-	-	-	-	-	-
PERCENT TRAINED IN FIRST AID	Variable Entered	ELS	INF	TADV	ADB	INV	ADVLS	NONAD	INAM	HKT	OPIN
	R^2 mult	.035	.042	.048	.052	.055	.058	.060	.061	.062	.062
	Proportion Gain	-	.007	.006	.004	.003	.003	.002	.001	.010	.000
	b*	.220*	.112	-.090	.063	-	-	-	-	-	-

Table 46 (Cont'd)

HSCC SCALE		STEP IN ANALYSIS 1	2	3	4	5	6	7	8	9	10
EQUIPMENT SUBSCORE	Variable Entered	INV	INF	OPIN	ADB	ADVLS	HKT	ELS	NONAD	INAM	-
	R^2 mult	.042*	.064*	.090*	.110*	.120*	.127	.130	.132	.133	-
	Proportion Gain	-	.022	.027	.198	.010	.007	.003	.002	.001	-
	b*	.184	.188	.170	-	-	-	-	-	-	-
DENTAL CARE	Variable Entered	ADB	ELS	HKT	INF	INV	INAM	TADV	ADVLS	NONAD	OPIN
	R^2 mult	.049*	.068*	.077	.083	.086	.088	.089	.090	.090	.090
	Proportion Gain	-	.019	.009	.006	.003	.002	.001	.001	.000	.000
	b*	.253*	.141	-	-	-	-	-	-	-	-
NUTRITION	Variable Entered	ELS	ADB	INAM	INV	NONAD	ADVLS	INF	HKT	-	-
	R^2 mult	.054*	.075*	.095*	.106*	.114	.116	.116	.116	-	-
	Proportion Gain	-	.021	.020	.011	.008	.002	.000	.000	-	-
	b*	.292**	.147	.143	-	-	-	-	-	-	-
ENVIRONMENTAL QUALITY AND SAFETY	Variable Entered	INV	INF	TADV	HKT	OPIN	ADB	INAM	ADVLS	NONAD	-
	R^2 mult	.042*	.055	.065	.069	.078	.074	.074	.074	.074	-
	Proportion Gain	-	.013	.010	.004	.004	.001	.000	.000	.000	-
	b*	.206*	-	-	-	-	-	-	-	-	-
ROUTINE TRANSPORTATION	Variable Entered	ADB	INAM	INF	HKT	ADVLS	INV	ELS	TADV	NONAD	-
	R^2 mult	.014	.026	.034	.050	.066	.071	.077	.080	.080	-
	Proportion Gain	-	.012	.008	.015	.016	.005	.006	.004	.000	-
	b*	-.114	-.109	-	-	-	-	-	-	-	-
MEDICAL RECORD CONTENT	Variable Entered	HKT	OPIN	ELS	INV	ADB	TADV	INF	ADVLS	INAM	NONAD
	R^2 mult	.053*	.115**	.132**	.150**	.161**	.168**	.182*	.184*	.186*	.188*
	Proportion Gain	-	.061	.017	.018	.010	.008	.013	.002	.002	.002
	b*	.321**	.268*	.211*	.152	.115	-.093	-	-	-	-
TOTAL ADJUSTED CHANGE	Variable Entered	ADVLS	ELS	INV	ADB	OPIN	TADV	INAM	HKT	NONAD	-
	R^2 mult	.096**	.163***	.217***	.239***	.248***	.259***	.264**	.266**	.266**	-
	Proportion Gain	-	.068	.053	.022	.010	.011	.005	.001	.000	-
	b*	.230*	.348**	.261*	.155	-	-	-	-	-	-

TABLE 47

MEANS AND STANDARD DEVIATIONS OF FIRST AND SECOND EVALUATIONS OF TRAINED VERSUS UNTRAINED SITES

(N=54 Trained Sites From Cycles A, B and C Versus N=17 Untrained Sites in Cycle F/F)
(Means With Standard Deviations Given Below in Parentheses)

HSCC Index	Group	First[1] Evaluation	Second[2] Evaluation
EXTERNAL PLANNING SCALE SCORE	A,B,C	37.96 (26.04)	53.24 (26.62)
	E/F	38.24 (30.77)	55.88 (24.25)
SPECIAL NEEDS SCALE SCORE	A,B,C	29.35 (30.54)	55.69 (31.37)
	E/F	32.47 (33.75)	44.20 (34.64)
Number of Types of Special Needs Subscore	A,B,C	4.18 (1.89)	4.96 (1.91)
	E/F	4.87 (1.92)	4.80 (1.86)
Number of Incidences of Special Needs Subscore	A,B,C	20.29 (27.71)	23.02 (33.26)
	E/F	22.73 (24.69)	24.53 (31.56)
Number of Children with Special Needs Subscore	A,B,C	13.43 (18.47)	12.25 (15.01)
	E/F	13.80 (10.28)	10.60 (12.09)
INTERNAL PLANNING AND ADMINISTRATION SCALE SCORE	A,B,C	81.43 (20.53)	93.43 (17.77)
	E/F	82.29 (18.66)	91.47 (13.62)

[1]The first evaluation represents pre-training for Cycles A, B and C but only an evaluation for Cycle E/F.

[2]The second evaluation is post-training for Cycles A, B and C but only a re-evaluation for Cycle E/F.

Table 47 (Cont'd)

HSCC Index	Group	First Evaluation	Second Evaluation
Proportion of Programs with Advocate Named as Person Responsible for Internal Planning Subscore	A,B,C	.259 (.442)	.389 (.492)
	E/F	.118 (.332)	.235 (.437)
Proportion of Programs with Advocate Among People Listed as Being Involved in Internal Planning Subscore	A,B,C	.833 (.376)	.963 (.191)
	E/F	.647 (.493)	1.000 (0.000)
Proportion of Programs Providing Screening Tests Subscore	A,B,C	.537 (.503)	.889 (.317)
	E/F	.412 (.507)	.529 (.514)
HEALTH SERVICES SCREENING SCALE SCORE	A,B,C	34.22 (30.20)	62.30 (30.71)
	E/F	30.35 (32.26)	45.06 (29.81)
Health Services Screening Consent Subscore	A,B,C	12.56 (32.13)	14.30 (26.88)
	E/F	6.82 (22.61)	38.83 (46.38)
Percent of Appropriate Tests Program Provides or Arranges Subscore	A,B,C	38.40 (27.52)	53.42 (29.19)
	E/F	45.82 (28.33)	50.64 (24.09)
Proportion of Programs Providing Medical Evaluation and Treatment Subscore	A,B,C	.833 (.376)	.981 (.136)
	E/F	.765 (.437)	.941 (.243)

TABLE 47--MEANS AND STANDARD DEVIATIONS OF FIRST AND SECOND EVALUATIONS OF TRAINED VERSUS UNTRAINED SITES (Cont'd)

HSCC Index	Group	First Evaluation	Second Evaluation
MEDICAL EVALUATION AND TREATMENT SCALE SCORE	A,B,C	47.46 (35.92)	77.50 (31.38)
	E/F	46.47 (42.42)	62.65 (33.63)
Medical Evaluation and Treatment Consent Subscore	A,B,C	18.66 (29.62)	20.43 (28.39)
	E/F	13.17 (30.80)	9.67 (17.98)
Medical Evaluation and Treatment Escort Subscore	A,B,C	69.27 (26.36)	79.98 (19.49)
	E/F	84.58 (27.95)	66.53 (36.89)
Percent Medical Evaluation and Treatment Program Provides or Arranges Subscore	A,B,C	47.11 (34.18)	49.91 (34.66)
	E/F	45.50 (33.44)	46.25 (30.75)
MEDICAL RECORD PROCESS SCALE SCORE	A,B,C	52.48 (19.01)	69.11 (19.65)
	E/F	57.41 (20.22)	63.88 (12.07)
HEALTH POLICIES AND PROCEDURES SCALE SCORE	A,B,C	41.32 (17.71)	70.39 (17.16)
	E/F	39.59 (17.78)	58.77 (19.97)
HEALTH EDUCATION SCALE SCORE	A,B,C	65.69 (21.04)	80.02 (16.30)
	E/F	65.77 (20.47)	68.18 (18.55)
STAFF HEALTH SCALE SCORE	A,B,C	61.48 (17.55)	72.46 (13.82)
	E/F	67.88 (16.28)	74.24 (7.66)

TABLE 47 (Cont'd)

HSCC Index	Group	First Evaluation	Second Evaluation
DENTAL CARE SCALE SCORE	A,B,C	63.48 (23.93)	73.70 (24.38)
	E/F	75.06 (21.16)	64.00 (27.91)
EMERGENCY EVACUATION AND DISASTER PLAN SCALE SCORE	A,B,C	52.78 (24.14)	60.74 (21.36)
	E/F	51.18 (23.15)	49.41 (21.93)
FIRST AID SCALE SCORE	A,B,C	56.15 (34.60)	75.46 (25.52)
	E/F	45.35 (29.61)	37.59 (34.68)
Percent Trained in First Aid of Those Required Subscore	A,B,C	69.65 (77.03)	115.32 (90.42)
	E/F	48.94 (65.04)	40.77 (67.39)
First Aid Equipment Subscore	A,B,C	75.93 (25.22)	76.85 (21.09)
	E/F	67.65 (32.79)	66.18 (26.43)
ENVIRONMENTAL QUALITY AND SAFETY SCALE SCORE	A,B,C	68.43 (10.13)	72.00 (9.63)
	E/F	67.41 (9.73)	70.29 (10.07)
NUTRITION SCALE SCORE	A,B,C	61.02 (16.99)	65.39 (13.60)
	E/F	68.41 (14.60)	67.82 (11.74)
Menu Subscore	A,B,C	58.89 (31.94)	74.94 (27.31)
	E/F	62.88 (30.98)	69.82 (22.01)

TABLE 47--MEANS AND STANDARD DEVIATIONS OF FIRST AND SECOND EVALUATIONS OF TRAINED VERSUS UNTRAINED SITES (Cont'd)

HSCC Index	Group	First Evaluation	Second Evaluation
TRANSPORTATION SCALE SCORE	A,B,C	71.14 (14.83)	72.63 (13.81)
	E/F	69.33 (16.95)	76.00 (15.99)
Proportion of Programs Providing Routine Transportation Subscore	A,B,C	.926 (.264)	.981 (.136)
	E/F	.941 (.243)	.941 (.243)
MEDICAL RECORDS CONTENT SCALE SCORE	A,B,C	23,49 (12.66)	45.98 (15.30)
	E/F	25.88 (8.00)	42.59 (9.98)

TABLE 48

SUMMARY OF CONTRASTS OF CYCLES A, B AND C VERSUS E/F
(Family Day Care Home Ommitted; N=54 in A, B and C; N=17 in E/F)

Index Number	Index Name	Results of Analysis of Variance (Significance Levels)			Planned Comparison		Residuals Test	
		Group Main Effect	Pre-Post Main Effect	Interaction	t-value	Significance	t-value	Significance
1	EXTERNAL PLANNING SCALE SCORE	-	.01	-	-.244	-	-.363	-
2	SPECIAL NEEDS SCALE SCORE	-	.01	-	1.20	-	1.28	-
3	Number of Types of Special Needs	-	-	-	1.31	-	.73	-
4	Number of Incidences of Special Needs	-	-	-	.16	-	.14	-
5	Number of Children with Special Needs	-	-	-	.52	-	.58	-
6	INTERNAL PLANNING AND ADMINISTRATION	-	.01	-	.42	-	.52	-
7	Advocate Named as Authority	-	.10	-	.09	-	.74	-
8	Advocate Among Those Listed	.01 (ABC > E/F)	.01	-	1.37	-	3.40	.01
9	Program Provides or Arranges Screening Tests	-	.001	.10	-1.73	-	- .66	-
10	HEALTH SERVICES SCREENING SCALE SCORE	-	.001	-	1.19	-	1.99	.05
11	Health Services Screening Consent	-	.05	.05	-2.11	.05	-2.33	.05
12	Percent of Appropriate Tests Program Arranges or Provides	-	-	-	.86	-	.46	-
13	Program Provides Medical Evaluation and Treatment	-	.01	-	-.23	-	.92	-
14	MEDICAL EVALUATION AND TREATMENT SCALE SCORE	-	.001	-	1.10	-	1.67	.10

TABLE 48--SUMMARY OF CONTRASTS OF CYCLES A, B AND C VERSUS E/F (Cont'd)

Index Number	Index Name	Results of Analysis of Variance (Significance Levels)			Planned Comparison		Residuals Test	
		Group Main Effect	Pre-Post Main Effect	Interaction	t-value	Significance	t-value	Significance
15	Medical Evaluation and Treatment Consent Subscore	-	-	-	.40	-	1.26	-
16	Medical Evaluation and Treatment Escort Subscore	-	-	8.82	2.96	.01	2.26	.05
17	Percent of Medical Evaluation and Treatment Program Arranges or Provides	-	-	-	.15	-	.30	-
18	MEDICAL RECORDS PROCESS SCALE SCORE	-	.001	.10	1.81	.10	1.15	-
19	MEDICAL RECORDS CONTENT SCALE SCORE	-	.001	-	1.48	-	1.25	-
20	HEALTH POLICIES AND PROCEDURES SCALE SCORE	.10 (ABC > E/F)	.001	-	1.50	-	2.13	.05
21	HEALTH EDUCATION SCALE SCORE	-	.05	-	1.70	-	2.55	.05
22	STAFF HEALTH SCALE SCORE	-	.001	-	.98	-	.01	-
23	DENTAL CARE SCALE SCORE	-	-	.05	2.49	.05	1.70	.10
24	EMERGENCY EVACUATION AND DISASTER PLAN SCALE SCORE	-	-	-	1.44	-	1.99	.05
25	FIRST AID SCALE SCORE	.01 (ABC > E/F)	-	.05	2.77	.01	4.67	.001
26	Percent Trained in First Aid of Those Required Subscore	.01 (ABC > E/F)	-	.10	1.77	.10	3.02	.01
27	First Aid Equipment Subscore	.05 (ABC > E/F)	-	-	.25	-	1.63	-
28	ENVIRONMENTAL QUALITY AND SAFETY SCALE SCORE	-	.05	-	.23	-	.53	-

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29	NUTRITION SCALE SCORE	-	-	-	1.12	-	.03	-
30	Menu Subscore	-	.05	-	1.00	-	.94	-
31	TRANSPORTATION SCALE SCORE	-	.10	-	-1.12	-	-1.09	-
32	Program Does Not Provide Routine Transportation Subscore	-	-	-	1.30	-	.86	-

Note: Two-tailed significance values are reported throughout the table.

SECTION V

PRESENTATIONS AND PUBLICATIONS

HAT PROJECT PUBLICATIONS AND PRESENTATIONS

PUBLICATIONS

1. "The Health Component of Child Care", Submitted to Child Welfare League, September, 1974.

2. "Health Advocacy: a need, a concept, a model", Susan S. Aronson, M.D. and Gretchen Lexow, R.N. in Children Today, January-February, 1975.

3. "Health Consultation in Child Care", in Child Care: A Comprehensive Guide, ed. Steveanne Auerbach-Fink, Behavioral Publications, (in press).

4. "Health Advocacy Training Project" in Advocacy for Children, DHEW Publication, Summer, 1975.

5. "Health Issues in Infant Care", in Voice for Children, December, 1975, 8:10:5.

6. "Group Response to Health Issues" in Voice for Children, January/ February, 1976, 9:1:10.

7. "Health and Safety Issues in Day Care", Susan S. Aronson, M.D. and Peggy Daly Pizzo, a concept paper prepared upon request by the Department of Health, Education and Welfare for an appropriateness study of the Federal Interagency Day Care Requirements, September, 1976.

PRESENTATIONS

1. National Association for the Education of Young Children Conference, "Health Consultation-Health Advocacy", Seattle Wash., November, 1973.

2. Delaware Valley Association for the Education of Young Children, "Health Advocacy Training Project", Philadelphia, Pa., 1973, 1974, 1975.

3. Child Welfare League, "The Health Component of Child Care", Atlantic City, N.J., April, 1974.

4. American Public Health Association Conference, "Health Advocacy", New Orleans, La., October, 1974.

5. Community Coordinated Child Care Council of Camden County, "Health Training Workshop", October, 1974.

6. Community Coordinated Child Care Council of Camden County, "Health Care for Children", November, 1974.

7. National Association for the Education of Young Children, "Keeping a Sound Body for a Sound Mind", Washington, D.C., November, 1974.

8. The Association for the Advancement of Health Education Convention, "Health Advocacy Training Project, Atlantic City, N.J., March, 1975.

9. Teachers College, Columbia University, "The Concept of Health Advocacy", New York, April, 1975.

10. The American Academy of Pediatrics and the Center for Women in Medicine, "Day Care: Its Impact on the Child, Family & Society", Philadelphia, Pa., April, 1975.

11. Association of Day Care Centers of Greater Philadelphia, "Caregivers: Developing Childrens' Full Potential", Philadelphia, Pa., March, 1975.

12. Delaware Valley Association for Education of Young Children Spring Conference, "Caring for Children under 2 1/2", Philadelphia, Pa., March, 1975.

13. Federation Day Care Services Spring Conference, "Development in Day Care", Philadelphia, Pa., May, 1975.

14. Ambulatory Pediatric Association, "Health Consultation in Day Care" Toronto, Canada, June, 1975.

15. Twenty-Second Annual Pennsylvania Health Conference, "Health Advocacy Training Project", Philadelphia, Pa., August, 1975.

16. Day Care and Child Development Council of America, "Health Care: EPSDT & Immunization Action Month", Washington, D.C., September, 1975.

17. American School Health Association, "Hustling for Health in Day Care", Denver, Colorado, October, 1975.

18. Day Care and Child Development Council of America, "Health Advocacy Training Project", Atlanta, Ga., November, 1975.

19. Pennsylvania Association for Child Care Administrators First Annual Meeting, "Health Issues in Day Care", Harrisburg, Pa., September, 1976.

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